PRINTED: 08/23/2011 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				ON	IB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	00	COMPI	LETED
		155066	A. BUIL			07/21/2	.011
			B. WING				
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					MADISON AVE		
EDGEW/	ATER WOODS			ANDER	RSON, IN46011		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	$\neg$	ID	I		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
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F0000							
			70		F0000		
	This visit was fo	or a Recertification and	F00	000	F0000		
	State Licensure Survey.						
	Survey dates: July 18, 19, 20, and 21,						
	2011						
	Facility number	: 000026					
	Provider numbe	r: 155066					
	l						
	AIM number: 100274820						
	Survey team:						
	Donna M. Smith	h. RN. TC					
	Tammy Alley, R						
	•						
	Toni Maley, BS	W					
	Census bed type	2:					
	SNF/NF: 67						
	Total: 67						
	101.07						
	Census payor ty	rpe:					
	Medicare: 15						
	Medicaid: 47						
	Other: 5						
	l						
	Total: 67						
	Sample: 15						
	Supplemental sa	ample: 6					
		<u>-</u>					
		ies reflect state findings					
	cited in accorda	nce with 410 IAC 16.2.					
	Quality review 7/2'	7/11 by Suzanne Williams, RN					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

775111

Facility ID:

FORM APPROVED OMB NO. 0938-0391

PRINTED:

08/23/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155066 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1809 N MADISON AVE **EDGEWATER WOODS** ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The resident has the right to be free from any F0221 physical restraints imposed for purposes of SS=E discipline or convenience, and not required to treat the resident's medical symptoms. The filing of this plan of correction F0221 08/20/2011 Based on observation, interview and does not constitute an admission record review, the facility failed to ensure that the alleged deficiency did in residents who resided on the Life Paths fact exist. This plan of correction Unit (Unit for residents with is filed as evidence of the facility's developmental disabilities) were not desire to comply with the regulatory requirements and to restricted to the unit without a restraint continue to provide quality care. assessment and/or medical justification The facility does ensure that for the use of a locked door restraint for 2 residents have the right to be free from any physical restraints that of 4 residents reviewed for restraint use are not required to treat the in a sample of 15 (Residents #42 & #46) resident's medical symptoms. and 5 of 5 residents reviewed for **Corrective action** restraint use in a supplemental sample of accomplished for those 6 (Residents #52, #51, #48, #38 & # 37). residents found to have been **affected:** The magnetic lock This deficient practice had the potential to and keypad system for the Life impact 15 of the 23 residents who resided Path Center doors was on the Life Path unit and were able to disconnected on July 20, 2011. independently ambulate or propel their Resident #52, #42, #46, #51, #48, own wheelchair. #38 and #37 were informed of the removal of the magnetic lock. How the facility identified other Finding include: residents having the potential to be affected: All residents During a 7/18/11, 9:00 a.m. initial residing on the unit have the potential to be affected. The observation of the facility, the facility had magnetic lock and keypad system three units, Moving Forward, Golden for the Life Path Center doors Orchards and Life Paths. The Life Paths was disconnected on July 20, unit (a specialized unit for developmental 2011 for all residents residing on Life Path Center. Residents disability) was separated from the rest of residing on Life Path Center were the facility by a locked door which re-assessed for risk of required a key pad code. The front half of elopement. Systemic Changes the facility, which was outside of the the facility made: The

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE SUI	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLET	ED
		155066	B. WIN			07/21/201	1
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹		1	MADISON AVE		
EDGEW	ATER WOODS			1	SON, IN46011		
EDGEW	ATER WOODS			ANDER			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	<b>+</b>	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	secured Life Pat	hs unit, included but was			magnetic lock and keypad sy		
	not limited to, a	large television area with			for the Life Path Center door was disconnected on July 20		
	overstuffed chairs; a small lounge with a				2011. Facility staff member		
	snack machine and soft drink machine;				residents, resident's respons		
	the business office where resident funds accounts were accessed; two units of resident rooms; the kitchen; an activity				parties and resident's physic		
					were advised that the magne		
					lock and keypad system for t	he	
	1	•			Life Path Center doors was		
	room and a large	cuming room.			disconnected. Physician's		
					orders for the secured unit w discontinued. Residents res		
	During a 7/18/11, 9:25 a.m., interview, LPN #2, who was the day charge nurse on the Life Paths unit, indicated the Life				on Life Path Center were	sidility	
					re-assessed for risk of		
					elopement. Elopement risk		
	Paths unit was a	secured unit with a			assessments will be complet	ed	
	locked door. He	indicated residents could			upon admission, change of		
		e Path unit without staff			condition and at least quarte		
	assistance.	o i war ware ware was swar			all residents who reside on the unit.	ne	
	assistance.				How the corrective action	will	
	D 7/10/1:	0.40 : :.			be monitored:	WIII	
	"	1, 9:40 a.m., interview,			be morntored.		
		or indicated the Life Path			The Life Path Center Dire	ctor	
		d door to maximize the			and Maintenance Supervi	I .	
	benefits of the sp	pecialized unit and offer			will monitor the doors in	301	
	safety.				accordance with the facilit	v's	
					decision to disconnect the	·	
	During a 7/18/11	1, 3:55 p.m., interview,			magnetic lock and keypad		
	1 -	ces Director indicated			system on July 20, 2011.		
		assessment regarding the					
		loor for each resident who			How often will the Quality		
					Assurance Committee be		
	lived on the Life Paths unit. The residents				involved in monitoring this pl	an of	
	1	vised to leave the unit,			correction? The Quality		
		per must enter the code in			Assurance Committee (CQI	,	
	order to unlock t	he door.			Committee) will meet at leas		
					monthly to review the trends auditing and staff skills valida		
	Review of a curi	ent, undated, facility			and make recommendations		
	1	"Residents that can			further staff development and		

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(EACH CORRECTIVE ACTION SHOULD BE
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DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE independently ambulate or propel self in action. wheelchair" which was provided by the How often and for how long will Administrator on 7/19/11 at 10:00 a.m. this plan of correction be indicated 15 of the 23 residents, who monitored? This plan of resided on the Life Path unit were able to correction will be monitored at least quarterly for at least 6 self ambulate or self propel their months and if at any time wheelchair. Residents #52, #42, #46, following this, issues are #51, #48, #38 and #37 were on this list. identified, the IDT will review and determine if further action During a 7/19/11, 11:00 p.m., interview, is necessary. the Administrator was queried as to how the locked doors of the Life Path unit Will monitoring occur on all shifts? Monitoring of this plan of assisted in maximizing programing or correction will occur on day and assisted in the treatment of developmental evening shifts. disabilities and if the resident who resided By what date the systemic on the unit had been assessed for the need changes will be completed: for a locked environment. August 20, 2011 During a 7/19/11, 12:30 p.m., interview, the Administrator indicated the facility administration had not considered the locked doors to the unit as a restraining device. The goal had been to create a small structured environment. The facility had not considered the option of closing the door as apposed to locking it in order to create a smaller purposefully designed unit. The facility had not assessed the residents for the need for a secured/locked unit to treat a medical symptom or condition. 1.) Resident #52's record was reviewed on 7/20/22 at 10:15 a.m.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155066		(X2) MULTIPLE Control  A. BUILDING  B. WING	ONSTRUCTION  00	COM	TE SURVEY  IPLETED  /2011	
	PROVIDER OR SUPPLIER	<u></u>	STREET 1809 N	ADDRESS, CITY, STATE, ZIP I MADISON AVE RSON, IN46011	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	CROSS-REFERENCED TO		TION SHOULD BE COMPLETIO  THE APPROPRIATE	
	but were not lim	urrent diagnoses included, ited to, Huntington's isorder, and dysphasia.				
	annual, Minimur which indicated sometimes under ambulated indep important to visi and enjoyed goir	endently, felt it was very t with family and friends ag outdoors. Resident impairment and need				
	LPN #2 indicated family member von another unit,	, 9:40 a.m., interview, d Resident #52 had a who resided in the facility and the resident greatly his family member.				
	Resident #52's rea.) an assessmer unit door restrain	nt for the use of a locked				
	· ·	medical symptom or required the use of a raint;				
	c.) a consent for restraint.	the use of a locked door				
		ntation which indicated a nit improved or enhanced				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066		(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	ľ	ESURVEY PLETED 2011		
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE  1809 N MADISON AVE ANDERSON, IN46011				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
IAG	the resident's quality the resident #52 was the Life Path unit 7/18/11, 12:00 p 7/18/11, 5:10 p.r 7/19/11, 8:10 a.r 7/20/11, 7:50 a.r During a 7/18/11 LPN #2 indicate to leave the unit 2.) Resident #42 on 7/18/11 at 11:	wing observations, s observed walking on t: .m. n. n. , 2:00 p.m. interview, d Resident #52 would ask to see his family member.  2's record was reviewed to a.m.  urrent diagnoses included, ited to, history of head	IAG	DEFICIENCE		DATE	
	quarterly, Minim which indicated was understood and had no signi behaviors.  Resident #42 had Annual Resident (assessment for idevelopmental developmental d	d a 9/13/10 "OBRA Review Case Analysis"					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	TE SURVEY  MPLETED  1/2011	
	PROVIDER OR SUPPLIER		1809 N	ADDRESS, CITY, STATE, ZIP I MADISON AVE RSON, IN46011	CODE	
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	unit door restrair	nt for the use of a locked				
	l '	required the use of a				
	c.) a consent for restraint.	the use of a locked door				
	d.) any documentation which indicated a secured/locked unit improved or enhanced the resident's quality of life.					
	During a 7/18/11, 10:30 a.m., observation, Resident #42 moved his wheelchair a very short distance.					
	3.) Resident #46 on 7/18/11 at 10:	s's record was reviewed 50 a.m.				
	Resident #46's co but were not lim retardation, spee depression.	•				
	quarterly, Minim which indicated understood other understood by of	d a current,7/4/11, num Data Set Assessment, the resident sometimes as and was sometimes thers, used a wheelchair not wander, and enjoyed				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066		(X2) MULTIPLE  A. BUILDING  B. WING	00	COM	te survey IPLETED 1/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1809 N MADISON AVE ANDERSON, IN46011				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY	TION SHOULD BE COMPLETIC THE APPROPRIATE		
IAU	going outside.	ESC IDENTIFTING INFORMATION)	IAU		,	DATE	
	"OBRA Annual I Analysis" which needed to participate recreational activities stimulation.  Resident #46's real.) an assessment unit door restraint.  b.) an identified condition which locked door restraint.  c.) a consent for restraint.  d.) any document secured/locked uthe resident's quality and the resident #51 on 7/20/11 at 10:  Resident #51's conductive to the condition which locked upon the resident and the resident and the resident and the resident #51's conductive to the conductive to the resident #51's conductive to	medical symptom or required the use of a raint; the use of a locked door tation which indicated a nit improved or enhanced ality of life.					
		understood others and					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	li i	PLETED  2011	
	PROVIDER OR SUPPLIER		STREET A 1809 N	ADDRESS, CITY, STATE, ZIP COE MADISON AVE RSON, IN46011	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	was understood to wheelchair, and to behaviors.	•				
	Resident #51's re a.) an assessmen unit door restrain	at for the use of a locked				
	l '	medical symptom or required the use of a aint;				
	c.) a consent for restraint.	the use of a locked door				
		ntation which indicated a nit improved or enhanced ality of life.				
	a.m., 11:35 a.m., 9:10 a.m. Reside propelling her what Life Paths unit. Unit being unloc a.m., Resident #5	ons on 7/18/11 at 9:45 5:15 p.m. and 7/19/11 at nt #51 was observed heelchair throughout the Following the Life Path ked on 7/21/11 at 9:25 51 was observed at the hatting with facility staff				
	5.) Resident #48 on 7/20/11 at 9:4	's record was reviewed 5 a.m.				
		arrent diagnoses included, ited to,mental retardation,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066		(X2) MULTIPI  A. BUILDING  B. WING	E CONSTR 00 —		(X3) DATE COMPI <b>07/21/2</b>	LETED	
	PROVIDER OR SUPPLIER		STR 180	9 N MAE	ESS, CITY, STATE, ZIP CODE DISON AVE I, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	ID PREFI TAG	CR	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
IAG	anxiety, and hype	LSC IDENTIFYING INFORMATION) ertension.	IAO		BELLEEL		DATE
	quarterly, Minim which indicated to others and was u a wheelchair for display disruptive. Resident #48 had plan problem regincrease activity approach to this pactivities in areast prefers such as frought (both located off Resident #48's real.) an assessment unit door restraint.  b.) an identified condition which locked door restraint.  c.) a consent for restraint.  d.) any documer secured/locked uthe resident's quarterly guarterly and the resident's quarterly and the secured posservation.	d a current, 11/11/10, care garding the need to participation. An problem was to provide in which the resident cont lounge and outside funit).  Second lacked: It for the use of a locked at; medical symptom or required the use of a aint; the use of a locked door attation which indicated a nit improved or enhanced ality of life.					
	a.m. and 5:15 p.r	n., Resident #48					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066		A. BUI	LDING	00	l` ´	E SURVEY PLETED 2011	
		133000	B. WIN				2011
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODI	3	
EDGEWA	ATER WOODS		1809 N MADISON AVE ANDERSON, IN46011				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
IAU		eelchair in the hallway of		IAG			DAIL
	6.) Resident #38 on 7/20/11 at 9:3	s's record was reviewed 0 a.m.					
		urrent diagnoses included, ited to, mild mental erebral palsy.					
	quarterly, Minim which indicated	d a current 7/4/11, num Data Set Assessment, the resident understood inderstood by others and fir for mobility.					
	Resident #38's rea.) an assessmer unit door restrain	nt for the use of a locked					
	· ·	medical symptom or required the use of a raint;					
	c.) a consent for restraint.	the use of a locked door					
	, ,	ntation which indicated a nit improved or enhanced ality of life.					
	7.) Resident #37 on 7/20/11 at 9:1	's record was reviewed 5 a.m.					

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NAME OF I	PROVIDER OR SUPPLIER		B. WINC	STREET A	ADDRESS, CITY, STATE, ZIP CODE MADISON AVE	0772172	2011
EDGEW	ATER WOODS				SON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	but were not limi	arrent diagnoses included, ited to, mental cal retardation, and					
	quarterly, Minim which indicated	I a current 5/18/11, num Data Set Assessment, sometimes understood ometimes understood by a wheelchair for					
	Resident #37's record lacked: a.) an assessment for the use of a locked unit door restraint;						
	l '	medical symptom or required the use of a aint;					
	c.) a consent for restraint.	the use of a locked door					
	d.) any documentation which indicated a secured/locked unit improved or enhanced the resident's quality of life.						
	titled "Physical F provided by the a	Restraints" which was administrator on 7/21/11 cated the following:					
		ill be considered only ive measures have failed,					

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		155066	A. BUILDING B. WING		07/21/2011
	PROVIDER OR SUPPLIER		1809 N	ADDRESS, CITY, STATE, ZIP CODE MADISON AVE	
	ATER WOODS		ANDER	SON, IN46011	
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	and the interdisciplinary team determines that they are needed to treat resident (s) medical symptoms."				
	defined as any m or mechanical de equipment attach resident's body th	hysical restraint is anual method or physical evice, material or led or adjacent to the leat the individual cannot leach restricts freedom of			
		raint assessment will be to the initiation of a			
	provided by the at 10:55 a.m. ind	dated, untitled document Administrator in 7/19/11 icated the Life Paths unit ed, locked unit from present date.			
F0254 SS=C	3.1-26(a) 3.1-26(g) 3.1-26(o) The facility must p linens that are in g	rovide clean bed and bath good condition.			
	record review, th linen was availab for residents' care observed for 3 of deficiency affect	ations, interviews, and e facility failed to ensure ole and in good condition e for 3 of 3 hallways f 5 days observed. This ed 2 of 4 residents rviewed (Resident #25	F0254	The filing of this plan of corredoes not constitute an admis that the alleged deficiency difact exist. This plan of corredis filed as evidence of the fact desire to comply with the regulatory requirements and continue to provide quality of the facility does provide clear	sion d in ction cility's to are.

li ´		(X2) M				(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED	
		155066	B. WIN		- <del></del>	07/21/2	011	
NAME OF	DD OLUDED OD GUDDUIEI		_!	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIEF			1809 N MADISON AVE				
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TAG	<b>†</b>	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
	1	of 2 residents in the group			bed and bath linens that are			
	meeting (Reside	nt #B and #C), and had			good condition. Corrective action accomplished for the			
	the potential to i	mpact 67 of 67 residents			residents found to have be			
	residing in the fa	acility.			affected: On July 19, 2011,			
					GFS technician inspected all			
	Findings include	··			washing machine formulas fo			
	i manigs niciade.				appearance, chlorine residua	al and		
	1 On 7/19/11 fr	com 11:05 a.m. to 11:40			pH of linens (brightness and			
					softness) and made any			
	· ·	61's transfer and personal			necessary adjustments. Regarding residents # 25, #5	-7		
	care was observed. One towel was observed to be dull in color with gray to				#B and #C, the facility compl			
					an inventory of facility linens			
	dark gray stained areas observed				linen identified as discolored	-		
	throughout the to	owel. Also, no			pulled from service, pre-soal	ked,		
	washcloths use v	was observed as CNA #4			laundered again and either p			
	completed the re	esident's personal care			back into service or discarde			
	_	the towel for cleansing			Any frayed or torn linens ide			
		the other side was used to			were discarded. Discarded I were replaced with new liner			
	1	during her personal care.			Hallway linen closets and ca			
	1 *	e during an interview,			were inspected, linens count			
					and replenished to meet the			
		ed she had trouble			needs of residents. How th	е		
	1 -	all of the time and had to			facility identified other			
	work without wa	ashcloths and towels.			residents having the potent			
					to be affected: Per the 256	57, It		
	2. On 7/18/11 at	t 10:55 a.m. during an			states all residents had the potential to be affected, thus			
	interview, Resid	ent #57 indicated 2 to 3			corrective actions and syster			
	times a week the	e facility did not have			changes apply to all resident			
		ths and towels for care.			Systemic Changes the facil			
	_	ed the linen had been			made: Laundry staff shift tir	nes		
	scratchy and "ro				were re-evaluated and			
	Scratciny and 10	agn as a coo.			adjustments made. On 7/20			
	2 0 7/10/11 6	9.10 a 4c 9.40			Regional Director of Laundry	and		
		rom 8:10 a.m. to 8:40			Housekeeping re-inserviced laundry staff with on checkin	a		
	· ·	ng was observed on the			washing machine chemical	ອ		
	hallway linen ca	rts:			product supply, chemical sup	oply		
						. ,		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPI	
		155066	B. WIN			07/21/2	011
NAME OF	PROVIDER OR SUPPLIER		'	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER			1809 N	MADISON AVE		
	ATER WOODS			L	SON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	·		DATE
		Forward hallway with			lines, linen sorting and loadir and proper washer program	ig	
	LPN #7: 15 gowns, 1 flat sheet, 12				selection. Laundry staff will		
	1 -	continent pads, and 6			observe linens daily while so		
	fitted sheets. Or	ne of the fitted sheet was			and folding linens for discolo		
	observed with a	saucer size yellow stain;			fraying. Any linen found to b		
	several pieces w	ere dingy in color;			discolored will be pulled out		
					service and further inspected the Laundry Supervisor/design	•	
	On the Golden C	Orchard hallway with LPN			for additional laundering or	grice	
	#7: 9 incontinent pads, 7 washcloths, 11 pillowcases, 3 fitted sheets, 2 flat sheets, 8				discarded. Frayed or torn lin	ens	
					will be pulled out of service a		
	gowns, and 34 towels. At least 4 of these				discarded. Inventory of line	n par	
	towels were very dingy in color, and 1				levels will continue to be		
	towels were very drigy in color, and i towel was observed with frayed edges all				conducted at least monthly be Laundry Supervisor/designed	-	
		, ,			new linens ordered as neede		
	around the towel	ı;			On 8/2/11, 8/5/11, 8/8/11 and		
					8/12/11, Staff Development		
		hallway with the			Coordinator in-serviced nurs	-	
	Housekeeping S	upervisor: 5 incontinent			department staff with post-te		
	pads, 5 flat sheet	ts, 21 pillowcases, 8			regarding immediate notifica of the charge nurse or	tion	
	gowns, and 12 fi	tted sheets. One of these			ED/designee if additional line	ens	
	fitted sheets was	observed with a quarter			are needed.	5110	
	size brown stain	on it. At this same time		How the corrective action will			
	during an intervi	lew, the Housekeeping			be monitored:		
	1 -	ated the stained fitted					
	1 ^	have been placed on this			How often and for how long	will	
		also indicated she had 2			this plan of correction be		
		or the laundry room,			monitored? A quality and qu		
		m. to 2:30 p.m. and from			CQI audit will be conducted (5 days per week) for two we		
		•			and monthly thereafter for at		
	1 -	p.m., and staff were able			6 months and if at any time		
	_	y done. She also			following this, issues are		
		d backup washcloths in			identified, the IDT will review	and	
		nd recently put more			determine if further action is		
	washcloths out.	Then, in this same			necessary.		
	hallway she was	observed to obtain a key			Administrator/designee wi	П	
	from the shower	room door and explained			Auministrator/designee wi	11	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155066	B. WIN	IG		07/21/2	011
NAME OF	PROVIDER OR SUPPLIE	}		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	MADISON AVE		
EDGEW	ATER WOODS			ANDER	SON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	<del> </del>	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1 *	up" linen cart locked up			conduct audits and will		
	1	She indicated this same			monitor for compliance.		
	1 -	ole to all staff, who should			How often will the Quality		
	be aware of this linen cart. This "back				Assurance Committee be		
	up" cart was obs	erved with sufficient			involved in monitoring this pl	an of	
	supply of all linen. Twenty-eight washcloths were counted on this cart with 4 of these 28 observed dingy in color also. Again, during an interview at this same time, the Housekeeping Supervisor indicated she had noticed the dingy laundry and had cooperate personnel				correction? The Quality		
					Assurance Committee (CQI		
					Committee) will meet at leas monthly to review the trends		
					auditing and staff skills validation		
					and make recommendations		
					further staff development and	d/or	
					action.		
	coming in today to check on the problem.				Mill manifesting and an all		
	At this same tim	•			Will monitoring occur on all shifts? Monitoring will occur	on all	
		ousekeeping Supervisor		shifts.			
		rayed towel on Golden			By what date the systemic	;	
		linen cart. She indicated			changes will be completed:	1	
	1 ·	not have been put on the			August 20, 2011		
	1	rt and was removed by					
	1 -	g Supervisor at this time.					
	the Housekeepin	ig Supervisor at this time.					
	4. On 7/19/11 fr	om 9:10 a.m. to 9:50					
	a.m., Resident #	61's personal care was					
	observed. Durin	ig this care observation, 3					
		d for her care as CNA #11					
		<sup>2</sup> 12 they were out of					
		this same time during an					
		Cans indicated they were					
	1	her linen cart other than					
		e opposite hallway. CNA					
	1	e would have to contact					
		g supervisor for more					
	1	same time during an					
	1 -	#7 also present in the					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2	2) MULTIPLE CON			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155066	A. I	BUILDING	00		COMPL 07/21/2	
		155000	В. V	WING			01/21/2	011
NAME OF I	PROVIDER OR SUPPLIEF	R		1	DDRESS, CITY, STA			
FDGFW	ATER WOODS				MADISON AVE SON, IN46011			
(X4) ID		STATEMENT OF DEFICIENCIES		ID				(X5)
PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIV	PLAN OF CORRECTION VE ACTION SHOULD BE		(A3) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCI DEF	ED TO THE APPROPRIAT FICIENCY)	E	DATE
	room indicated s	she was unaware of any						
		ain linen besides the linen						
	cart down the opposite hallway. She							
	indicated the Housekeeping supervisor							
	should be notifie	ed concerning the linen.						
		rom 1:15 p.m. to 2:50						
	p.m., the environmental tour was							
	conducted. In the laundry room during an							
	interview, Laundry aide #15 indicated if a							
	piece of linen was stained, she indicated							
	the linen would not be for resident's use.							
	At this same tim	-						
	1 -	ated the corrections he had						
	I -	improved the laundry, for						
	example, made i	t softer and cleaner.						
	The "SERVICE"	REPORT," dated 7/19/11,						
		the Administrator on						
		a.m. This service report						
		ergency call was made to						
		linen was indicated as						
	1	it dingy and rough" with						
	all chemicals pur							
	6. During a 7/9/							
	_	up interview with 2						
	_	C) who were identified as						
	,	the Administrator on						
	7/18/11 at 10:55	a.m., the following						
	concerns regardi	ing washcloths and						
	towels were mad	de:						
	a.) 2 to 3 times a week they use a towel							
	as a washcloth b	ecause they are out of						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID	77511	11 Facility II	D: <b>000026</b>	If continuation sh	eet Pa	ge 17 of 66

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/21/2011	
	PROVIDER OR SUPPLIER		STREET A 1809 N	ADDRESS, CITY, STATE, ZIP CODE MADISON AVE RSON, IN46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
ind	washcloths.	ESC IDENTIFY FING IN ORMATION)	170		DAIL
	stained and fraye you do not want c.) In the recent	ths and towels are often d. They are so stained to use them.  past there was a problem selling like it had not			
	been properly cle 7. During an into 25 on 7/20/11 at there are not eno provide her care.	· ·			
	Clean Linen" wa Administrator on and deemed as co Clean Linen" pol To provide clean residentAn ade	olicy titled "Handling s provided by the 17/20/11 at 8:25 a.m., arrent. The "Handling icy indicated: "Objective, fresh linen to each quate supply of clean ailable at all times"			
	3.1-19(g)(4) 3.1-19(g)(5)				
F0282 SS=D	facility must be pro in accordance with plan of care. Based on observa	ded or arranged by the ovided by qualified persons a each resident's written ations, record reviews, the facility failed to	F0282	The filing of this plan of correction does not constitut admission that the alleged	08/20/2011 te an

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155066 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1809 N MADISON AVE **EDGEWATER WOODS** ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE deficiency did in fact exist. This ensure the physician's orders were followed plan of correction is filed as concerning an abductor pillow for 1 of 1 resident evidence of the facility's desire to with an abductor pillow (Resident #61), for the comply with the regulatory application of bunny boots for 1 of 2 residents requirements and to continue to observed (Resident #61), for the daily provide quality care. The facility administration of all medications for 1 of 9 does provide services by qualified residents reviewed (Resident #61), and for the person/care plan. Corrective correct amount of sliding scale insulin coverage action accomplished for those for 1 of 1 resident (Resident #57) in a sample of residents found to have been affected Regarding resident #61, a medication error was Findings include: completed regarding the Plavix and Seroquel. The medication 1. Resident #61's record was reviewed on 7/18/11 was available. The attending at 2:30 p.m. The resident's diagnoses included, physician was notified. CNA #4 but were not limited to, open reduction internal and #5 were immediately fixation of the right hip, dementia, anemia, and re-inserviced on the abductor debility. placement. CNA #11 and #12 were re-inserviced on the use of The physician order, dated 7/13/11, was abductor booties and utilizing the CNA pillow when in bed and in her wheelchair. assignment sheet. Regarding The physician order, dated 7/18/11, was bunny resident #57, Medication error boots on at all times except for activities of daily report regarding the sliding scale living care. insulin was completed and the The physician order, dated 7/01/11, was Plavix attending physician was notified. (coronary artery disease) 75 milligrams (mg) give There was no negative outcome. 1 tablet daily and Seroquel (dementia) 50 mg take How the facility identified other 1 two times a day. residents having the potential to be affected: The customer The "MEDICATION ADMINISTRATION care team made resident rounds RECORD" for 7/2011 indicated the resident's for placement of assistive devices medication. Plavix, was unavailable for any issues identified were administration on 7/01 to 7/04, inclusive and the immediately addressed. A medication, Seroquel, was unavailable for sliding scale insulin audit was completed on all residents administration on 7/04 at 8:00 p.m. receiving sliding scale insulin for the last 30 days and any issues On 7/18/11 from 11:05 a.m. to 11:40 a.m., identified were addressed. Resident #61's transfer and personal care was Systemic Changes the facility observed. After the resident was transferred to her made: On 8/2/11, 8/5/11, 8/8/11 bed, CNA #4 removed the resident's abductor

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155066	B. WIN	IG		07/21/2	011
NAME OF I	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
THE OF I	NO VIDER OR SOLVER			1809 N	MADISON AVE		
	ATER WOODS			L	SON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		resident's legs. The resident			and 8/12/11, Staff Developm		
	was then observed to be transferred from side to				Coordinator inserviced nursi	•	
		ductor pillow by CNA #4 and			staff with post-test on placer	nent	
		onal care was performed.			of assistive devices, use of	CNIA	
		d the removal of the soiled			abductor pillows and utilizing	CNA	
	_	f her personal care, and			assignment worksheets. All residents with new orders/ch	ange	
		ew brief. After the resident's			in condition will be discussed	-	
		, the abductor pillow was			the clinical meeting immedia		
	repositioned between her legs.  On 7/19/11 at 8:40 a.m. during an interview,				following morning meeting.	-	
					plan interventions will be		
		_			reviewed and updated at tha	t	
	Physical Therapy #9 indicated the abductor pillow should be kept in place, which was between the				time. CNA assignment shee	ts	
	resident's legs, to keep the resident from crossing				will be updated to reflect cha	inges	
	her feet/legs while she was being turned.				made to the resident's care	olan	
	ner recoregs winter	she was being turned.			during the meeting. All new		
	On 7/19/11 at 9:05	a.m. during an interview, the			nursing employees will be tra		
		indicated the CNAs were			on CNA assignment sheets	and	
	_	eir orientation concerning an			assistive devices during		
		it was on their orientation			orientation. In the event that		
		they were to read the			medication is not available the nurse will attempt to locate to		
		en, would sign off on it. She			medication. Check the EDK		
		te inservice was held			the medication; contact the	101	
	concerning Residen	t #61's abductor pillow.			pharmacy for stat delivery.	Гһе	
					physician will be notified if no		
	The "ABDUCTION	PILLOW" validation skill			and the DNS/designee will b		
		e Nursing Consultant on			contacted as needed. On 8		
		n. The information included			8/5/11, 8/8/11 and 8/12/11, S	Staff	
		illow should be applied with no			Development Coordinator		
	information concern	ning when it should be used.			re-inserviced licensed nurse		
					post-test on insulin administr		
		a.m. after Resident #61's			and documentation via slidin	g	
		ompleted by CNA #11 and			scale.	***	
		ent remained in her bed to rest			How the corrective action	WIII	
		on. Her booties were observed			be monitored:		
	in a chair in her roo	m.					
	On 7/20/11 at 10.20	) a manual at 2:45 m m			How often and for how lor	-	
		a.m. and at 3:45 p.m.,			will this plan of correction	be	
		bserved in her bed without her			monitored?		
	booties on. At this	same time her booties were					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155066 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1809 N MADISON AVE **FDGFWATER WOODS** ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE observed in her chair in her room. This plan of correction will be monitored for at least 6 On 7/21/11 at 9:45 a.m. during an interview, LPN months and if at any time #13 indicated Resident #61's booties were being following this, issues are used as a skin preventive measure. identified, the IDT will review and determine if further action On 7/21/11 at 9:50 a.m. during an interview, the is necessary. Director of Nursing (DON) indicated a new physician order, for example, Resident #61's The charge nurses will booties, was reviewed in the daily meetings and monitor for placement of then, placed on the CNA assignment sheets and the assistive devices by use of the care plan. At this same time during an interview, the DON indicated the resident's Plavix and MARS and TARS during their daily rounds. Any issues Seroquel medication had been delivered on 7/01/11 and was available to be given as the identified will be addressed. medications were in the medication drawer. A resident rounds CQI audit 2. Resident #57's record was reviewed on 7/18/11 will be completed for assistive at 5:20 p.m. The resident's diagnoses included, devices at least daily (5 days but were not limited to, diabetic mellitus. per week) for two weeks, weekly for four weeks and The physician's order, dated and signed 7/13/11, then as determined by was Novolog insulin sliding scale 4 times daily. members of the IDT team. Insulin coverage was 100 - 124 = 1 unit (u); 125 -The DNS/designee will be 149 = 2 u; 150 - 174 = 3 u; 175 - 199 = 4 u; 200 - 199 = 4 u; 149 = 2 u; 150 - 174 = 3 u; 175 - 199 = 4 u; 190 - 199responsible for coordination of 224 = 6 u; 225 - 249 = 7 u; 250 - 274 = 9 u; 275 - 274 = 9 u; 275the monitoring. 299 = 10 u: 300 - 324 = 12 u: 325 - 349 = 14 u: 350 - 374 = 15 u; and 375 - 399 = 17 u. Facility will complete an audit at The "Capillary Blood Glucose Monitoring Tool" least quarterly to review carts for availability of medications. for 7/2011 indicated the following: Pharmacy will complete a quality assurance visit to review carts for On 7/06 at 5:00 p.m., the blood sugar (BS) was availability of medications. 127 with 1 u of insulin coverage given (2 u for BS Discrepancies will be reported to of 125 - 149): the DNS. The DNS will be On 7/10 at 9:00 p.m., the BS was 324 with 14 u of responsible to monitor. insulin coverage given (300 to 324 u = 12 u); On 7/17 at 5:00 p.m., the BS was 189 with 3 u of A sliding scale insulin audit will be insulin coverage given (175 - 199 = 4 u). completed at least weekly and staff will be re-inserviced as

l i		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	(X2) MULTIPLE CO  A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  07/21/2011
	PROVIDER OR SUPPLIER		1809 N	ADDRESS, CITY, STATE, ZIP CODE MADISON AVE RSON, IN46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
F0315 SS=D	information was req p.m., the 7/10 at 9:0 p.m. insulin coverage On 7/21/11 at 12:55 Director of Nursing information concern 3.1-35(g)(2)  Based on the resident who enter indwelling cathete the resident who enter indwelling cathete the resident who is incappropriate treatmurinary tract infect normal bladder fur Based on record interview, the fact anchored cathete was provided in a possibility of information observed with an (Resident # 25) at 10 p.m. insuling the fact and the fact and the fact and the fact anchored cathete was provided in a possibility of information of the fact and the fact and the fact and the fact and the fact anchored cathete was provided in a possibility of information with an (Resident # 25) at 10 p.m. insulin coverage of the fact and the f	p.m. during an interview, the indicated she had no further ing the sliding scale insulin.  dent's comprehensive acility must ensure that a rest he facility without an r is not catheterized unless cal condition demonstrates in was necessary; and a continent of bladder receives lent and services to prevent ions and to restore as much	F0315	How often will the Quality Assurance Committee be involved in monitoring this p correction? The Quality Assurance Committee (CQ Committee) will meet at lea monthly to review the trend auditing and staff skills valid and make recommendation further staff development at action.  Will monitoring occur on all shifts? Monitoring will occur shifts.  By what date the system changes will be completed August 20, 2011  The filing of this plan of correction does not constitut admission that the alleged deficiency did in fact exist. plan of correction is filed as evidence of the facility's de comply with the regulatory requirements and to continu provide quality care. The fi does ensure that a resident enters the facility without ar indwelling catheter is not	I sist is of dations is for ind/or in

<b>∥</b> ′		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155066	B. WIN			07/21/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t .					
EDCE/W/	ATER WOODS			1	MADISON AVE SON, IN46011		
EDGEWA	AIER WOODS			ANDER	30N, IN46011		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					catheterized unless the resid	lent's	
	Findings include				clinical condition demonstrat	es	
	1 111411185 11141444	•			that catheterization was		
	1 The manual Composition # 25				necessary. A resident who	is	
	1. The record for Resident # 25 was				incontinent of bladder does		
	reviewed on 7/19/11 at 8:20 a.m.				receive appropriate treatmer	nt and	
					services prevent UTI.		
	Current physician orders for July 2011				Corrective action		
indicated the resident had an anchored catheter.					accomplished for those residents found to have be		
	catricter.				<pre>affected Regarding Reside #25, as stated in the 2567, tl</pre>		
	A physician order dated 6/21/11 indicated				ADNS intervened and instru		
					the CNAs to lower the draina		
	an order for a urinalysis with culture and sensitivity.				bag below the bladder.	.90	
					Regarding Resident #61, all		
	,				nursing staff was re-educate	d on	
	A urina cultura d	lated 6/24/11 indicated			pericare. How the facility		
					identified other residents		
		greater than 100,000			having the potential to be		
	gram negative ro	ods, indicating a urinary			affected: A catheter		
	tract infection.				assessment was completed	on all	
					residents with catheters. An	-	
	A physician orde	er dated 6/24/11 indicated			resident who is incontinent o	f	
		ofurantoin 100 milligrams			urine has the potential to be		
		given twice daily for 7			affected. Systemic Change		
	` ′	given twice daily 101 /			the facility made: On 8/2/1		
	days.				8/5/11, 8/8/11 and 8/12/11, S Development Coordinator	otan	
					presented an inservice to the	2	
	During a transfer	r observation of Resident			nursing staff with post-test a		
	# 25 on 7/18/11 a	at 11:15 a.m., CNA # 25			return-demonstration regard		
	removed the anc	hored catheter bag and			foley catheter care and	J	
		dignity bag and placed it			positioning, use of washcloth	าร	
	on the floor unde				during pericare and completi	ng	
					pericare from front-to-back o		
		anchored catheter bag			females. All nursing staff ha		
		full of yellow urine. CNA			skills validations completed of	on	
	# 25 picked up tl	ne drainage bag and			•		
	handed it to CNA	A # 4. The drainage bag				.:II	
					Catheters. DN5/designee w	/III	
	# 25 picked up the handed it to CNA				pericare and transfers of residents with anchored catheters. DNS/designee w		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	(X2) MULTIPLE CC  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/21/2011
	PROVIDER OR SUPPLIER		1809 N	ADDRESS, CITY, STATE, ZIP CODE MADISON AVE RSON, IN46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	that time, the As Nursing arrived	sistant Director of in the room and informed er the drainage bag	TAG	make rounds throughout the facility to ensure pericare are catheter care is provided appropriately. How the corrective action be monitored:  Skills validations will cont to be completed on perical and transfers of residents anchored catheters.  How often and for how long this plan of correction be monitored? A catheter CQI be completed daily for five of then weekly times four weel quarterly thereafter for at least months and if at any time following this, issues are identified, the IDT will review determine if further action is necessary.  How often will the Quality Assurance Committee be involved in monitoring this properties correction? The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends auditing and staff skills valid and make recommendations further staff development are action.  Will the DNS/Designee make these rounds on all shifts? Tons/Designee will make roon all shifts.	end will inue are s with will days, ks and ast 6 v and st s of lations s for id/or de The
			ı	l .	l .

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	(X3) DATE SURVEY  COMPLETED  07/21/2011
	PROVIDER OR SUPPLIER		STREET A 1809 N	ADDRESS, CITY, STATE, ZIP CODE MADISON AVE RSON, IN46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
				Will monitoring occur on a shifts? Monitoring will occushifts.  By what date the system changes will be completed August 20, 2011	ur on all
	7/18/11 at 2:20 p	s record was reviewed on .m. The resident's ed, but were not limited failure.			
	indicated the resindicated,	Physical," dated 6/21/11, dent's past medical but was not limited to, c recurrent urinary tract			
	Resident #61's tr was observed. C resident had been Next, she was ob the same area of sweeping motion abdomen, up and across the abdom left groin, and th middle followed area in the same resident was patt	11:05 a.m. to 11:40 a.m., ansfer and personal care CNA #4 indicated the incontinent of urine. In served to cleanse with the cloth in the same across the lower across the lower I down the right groin, men, and up and down the en, up and down the by rinsing the personal manner. After the ed dry, her rectal care and the resident was			
	3. The "Peri-Car	re" policy was provided			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066			(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/21/2011
	ROVIDER OR SUPPLIER		1809	ET ADDRESS, CITY, STATE, ZIP CODE 9 N MADISON AVE DERSON, IN46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
mg	by the Administra	ator on 7/20/11 at 8:25 t policy indicated the			Bittle
		e perineum for prevention ation and to contribute to itive self-image			
	and wet wash clo Always wash fro to spread the labi	sing peri care product th, wash labia first. m front to back. Be sure a and cleanse se and dry completely"			
	3.1-41(a)(2)				
F0319 SS=D	a resident, the faci resident who displi- adjustment difficult treatment and serva assessed problem Based on observa	ations, record review, and	F0319	The filing of this plan of correduces not constitute an admis	
	resident with adjusted resulting in anxiety evaluated to main resident's adjustn	cility failed to ensure a custment difficulty ety was assessed and entain/improve the enent to the facility for 1 mitted residents reviewed		that the alleged deficiency di fact exist. This plan of corre is filed as evidence of the fact desire to comply with the regulatory requirements and continue to provide quality of	id in ction cility's to

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155066	B. WIN			07/21/2	011
		I	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	MADISON AVE		
FDGFW	ATER WOODS			1	SON, IN46011		
		CTATEMENT OF DEPLOYENCIES		L			(7/5)
(X4) ID		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	l `	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
IAG			+	IAG	The facility does ensure that	2	DATE
	in a sample of 15	).			resident who displays menta		
	(Resident #59)				psychosocial adjustment diffi		
					receives appropriate treatme		
	Findings include	:			and services. Corrective ac	ction	
					accomplished for those		
	1. Resident #59'	s record was reviewed on			residents found to have been		
	7/18/11 at 4:40 p.m. The resident's				affected Regarding Reside		
	_	led, but were not limited			#59, the physician was conta and an order was received for		
	1 -	lisease. The resident was			psychiatric evaluation and	ла	
	1	acility on 7/02/11.			treatment for the resident. S	ocial	
	damitted to the r	actively on 7702711.			Services assisted resident w	ith	
	The undeted "Co	aiol History &			adjustment issues. How the	•	
	The undated "Social History &				facility identified other		
	1 *	sessment" indicated the			residents having the potent	ial	
		nitted on 7/02/11. The			to be affected: All newly		
	1	tional Status/How does			admitted residents will be reviewed for difficulties in		
	the resident cope	e?" indicated the resident			adjustment. Any issues iden	tified	
	was confused an	d anxious. The "Event(s)			will be communicated to the		
	Leading to Place	ement and Reason(s) for			attending physician. Syster	nic	
	Admission" was	indicated as increased			Changes the facility made:		
	confusion. The	"Mood or behaviors			8/2/11, 8/5/11, 8/8/11 and 8/1	2/11,	
	noted" was indic	ated as the resident was			Social Services provided an		
	anxious.				in-service for all staff membe with post-test on behavior	ers	
	difficus.				management. Any resident	s	
	The "Perident D	rogress Notes" indicated			identified with symptoms of		
		logiess notes indicated			difficulty adjusting, staff will		
	the following:				complete a behavior form an		
					communicate to the charge r		
		00 p.m., the resident was			and social services. A care paid will be developed with	oian	
		acility. He was indicated			interventions to address the		
		used, moderately anxious			behavior. This will be		
	at times, and was	s forgetful.			communicated to the staff via	a the	
	On 7/03/11 at 1:4	40 a.m., the resident was			CNA assignment sheet and o	care	
	very confused ar	nd unable to remember			plan. Any new or worsening		
	1 -	s of why he was here for			behaviors will be reviewed by IDT and care plan will be rev		
	so long.	•			ו בו and care plan will be fev	iscu	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155066 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1809 N MADISON AVE **EDGEWATER WOODS** ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE as indicated. Social Services will On 7/04/11 at 11:21 a.m., the resident was work with all new admissions to restless and agitated. He was assist in the adjustment continuously asking to go home and process. leave. The resident stated he was left here How the corrective action will and was being held. The resident was be monitored: redirected numerous times, which were How often and for how long will unsuccessful, and required medication to this plan of correction be calm the resident down. monitored? Behavior On 7/04/11 at 3:15 a.m., the resident was management/unnecessary drug noted to have been given frequent CQI will be completed weekly times four weeks, monthly times reassurances, which help some but were three months and then quarterly quickly forgotten. thereafter for at least 6 months On 7/05/11 at 11:40 p.m., the resident was and if at any time following this. indicated as alert but very confused, and issues are identified, the IDT will review and determine if further "anxious at times," with medication given action is necessary. at 6:00 p.m. "with some relief." On 7/10/11 at 2:15 p.m., the resident was Social Services Director will be sitting in the hallway looking around and responsible for compliance. interacting with staff with no further Will monitoring occur on all complaints. He was medicated for shifts? Monitoring will occur on anxiety. day and evening shifts. On 7/12/11 at 3:06 a.m., the resident was confused most of the time but alert to self. How often will the Quality Assurance Committee be On 7/12/11 at 7:30 p.m., the resident was involved in monitoring this plan of very forgetful and became anxious at correction? The Quality times. Assurance Committee (CQI On 7/15/11 at 7:52 p.m., the resident was Committee) will meet at least monthly to review the trends of alert to self, disorientated to time and auditing and staff skills validations place, and stated "why do you hold people and make recommendations for in here like a jail?" further staff development and/or On 7/17/11 at 3:47 a.m., the resident was indicated as suffering from Alzheimer's By what date the systemic changes will be completed: and did not understand why he was her August 20, 2011 and why he could not go home.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066		A. BUIL	DING	NSTRUCTION 00	(X3) DATE ( COMPL 07/21/2	ETED	
		100000	B. WING		DDRESS, CITY, STATE, ZIP CODE	0172172	011
NAME OF	PROVIDER OR SUPPLIE	2			MADISON AVE		
	ATER WOODS			ANDER	SON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	<b>+</b>	00 p.m., the resident was		IAG	,		DAIL
		dly to moderately anxious					
	and was medicated per physician's orders.						
		2:12 p.m., the resident was					
		rgetful and asked					
		ons regarding his					
	discharge.						
	No information						
	coping/adjusting to his admission and also						
	concerning the resident's anxiousness						
	were indicated.						
	On 7/19/11 at 7:	50 a.m., Resident #59					
		the Moving Forward					
	_	aiting breakfast. He was					
		he was, what he was					
	1	ho were "all these					
		fast preparations were					
	being completed						
	On 7/20/11 at 10	):20 a.m., Resident #59					
		his wheelchair in the					
		urse's station. He was					
		ng where he was and who					
		re in the hallway.					
		-					
	On 7/21/11 at 8:	45 a.m. during an					
	interview, the D	irector of Nursing (DON)					
	indicated the sta	ff did stop and answer					
	Resident #59's q	uestions.					
		50 a.m. during an					
	interview, the A	ctivity Director indicated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/21/2011			
NAME OF PROVIDER OR SUPPLIER  EDGEWATER WOODS			STREET ADDRESS, CITY, STATE, ZIP CODE  1809 N MADISON AVE ANDERSON, IN46011				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F0323 SS=D	and was presently concerning 1 to 1 plan was presently problem was resiparticipate in grostated interest as time during an inindicated a physical on 7/19/11 for psevaluate and treation of 21/11 at 12 interview, Social he did not have a concerning Residual of 2 residents reviewes, the fapersonal body also of 2 residents reviewed to a resident at more resident reviewed.	:50 p.m. during an Services #16 indicated my information dent #59's anxiousness.  Insure that the resident ins as free of accident sible; and each resident e supervision and assistance	F0323	The filing of this plan of corre does not constitute an admis that the alleged deficiency difact exist. This plan of corre is filed as evidence of the fact desire to comply with the regulatory requirements and continue to provide quality of the facility does ensure that resident environment is as fraccidents as possible and assistive devices are provide prevent accidents. Correct	esion d in ction cility's to are. the ee of		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155066	A. BUII B. WIN			07/21/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					MADISON AVE		
EDGEWATER WOODS							
EDGEW	ATER WOODS			ANDER	RSON, IN46011		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	Findings include	<del>2</del> :			action accomplished for th		
					residents found to have be		
	1. Resident #61	s record was reviewed on			affected Regarding Reside		
	1	o.m. The resident's			#61, resident was re-assess		
	1	led, but were not limited			fall risk and the care plan wa updated with additional	15	
	1 ~				interventions. Regarding		
	1	on internal fixation of the			Resident #18, the ADNS rer	noved	
	1 - 1	itia, and debility. The			the teaspoon and provided t		
	resident was adr	nitted to the facility on			resident with a small spoon.		
	7/01/11.				Speech Therapy will continu	ie to	
					work with this resident on ea	-	
	The physician order, dated 7/01/11, was bed alarm and wheelchair alarm for				techniques. How the facili	ty	
					identified other residents		
	safety.	incolonian alarm for			having the potential to be		
	saicty.				affected: All residents with		
					personal alarms were immediately checked for		
	1	ort," dated 7/02/11,			appropriate placement and		
	indicated the resident was found in her room lying on her left side next to her bed on this same day at 6:50 a.m. The				function, verified and then		
					documented on the MAR/TA	AR.	
					No other residents in the fac	cility	
	resident indicate	ed she was trying to go to			eat with a small (baby) spoo		
	the bathroom. The environmental factor was the resident was a new admission to the facility. The interventions indicated as "put into place to prevent another fall" were 15 minute checks, and the resident was sent to the hospital for X-rays. She returned to the facility with no apparent			Systemic Changes the facili			
					made: On 8/2/11, 8/5/11, 8		
					and 8/12/11, Staff Developm		
					Coordinator provided an ins		
					to nursing staff with post-tes regarding: 1) Placement of		
					alarm, utilization of CNA		
					assignment sheets and wha	t to	
					do in the event that a device		
	injury. The "Pro	ogress Note," dated			not working or missing. 2)		
	7/05/11 at 8:53 a.m., indicated in the IDT (Interdisciplinary Team) meeting				Checking meal tickets for		
					appropriate assistive device		
		resident's fall from her bed			communicating to the cook i		
	1				assistive device is missing p		
		nroom, interventions were			serving the meal. How the corrective action will be		
	to place the resident on a bowel and				monitored: How often and	for	
		n, maintain her alarm to			how long will this plan of	101	
bed, and continue the current therapy with							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155066 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1809 N MADISON AVE **EDGEWATER WOODS** ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE correction be monitored? therapy aware of the fall. Resident rounds CQI tool will be completed daily (5 days per The "Event Report," dated 7/06/11, week) for two weeks, weekly indicated the resident was found in her times four weeks, monthly times three months and quarterly room sitting on the floor with her legs thereafter for at least 6 months straight out in front of her on this same and if at any time following this, day at 6:00 a.m. The resident had been issues are identified, the IDT will incontinent of urine at this time. She also review and determine if further indicated she was attempting to go to the action is necessary. DNS will be responsible for the coordination of bathroom. The intervention to prevent this monitoring. How often and for another fall was 15 minute checks. The how long will this plan of "Progress Note" in this report included. correction be monitored? Meal but was not limited to, the following: observation/preparation CQI tool will be completed daily (5 days On 7/06/11 at 6:00 a.m., the alarm was per week) times two weeks at indicated as "in place" with no every meal, weekly times four information indicated if it was functional weeks and then quarterly thereafter for at least 6 months and/or alarming. The resident was and if at any time following this, assisted back to her bed as "no gross issues are identified, the IDT will deformities observed." At 8:29 a.m. on review and determine if further this same day, the resident was action is necessary. Dietary complaining of pain to the right leg. After Services Manager will be responsible for monitoring. How the physician was notified, a 1 time pain often will the Quality medication was given. At 10:14 a.m. on **Assurance Committee be** this same day, the resident was involved in monitoring this complaining of right upper leg pain with plan of correction? The Quality the limb indicated as appearing shorter Assurance Committee (CQI Committee) will meet at least and with external rotation with tenderness monthly to review the trends of along the femur (leg bone). The physician auditing and staff skills validations was notified and the resident was sent to and make recommendations for the emergency room for X-rays. further staff development and/or action. Will monitoring occur on all On 7/14/11 at 9:45 a.m., the "Fall" IDT shifts? Monitoring will occur on all meeting indicated the resident had shifts. By what date the returned from the hospital after the fall. systemic changes will be The resident was started on a 3 day bowel completed: August 20, 2011

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NAME OF PROVIDER OR SUPPLIER  EDGEWATER WOODS			B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1809 N MADISON AVE  ANDERSON, IN46011				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	the toileting programs completed. alarm, mat on the bed in the lowest buddy in the when present intervent this same date an interventions with to be placed again mattress with sm reminders were a resident was not would be reasses not indicated.  The right hip x-raindicated the resident was not would be reasses not indicated.  The right hip x-raindicated the resident was angulation.  On 7/19/11 at 8:4 transfer was observed the Hoyer sling, from her wheelch hed. No personat the wheelchair we this transfer. At interview, LPN # found it to be in the search of	ern, and would continue gram until the assessment. The bed alarm, chair e floor beside bed, the a position, and a lap selchair were indicated as ions. At 4:54 p.m. on a dafter discussing the family, the bed was not the wall and a all bolsters for perimeter added. Also, if the using the siderails, they sed and discontinued if any, dated 7/06/11, dent has a fracture oral neck with a 90 degree deformity.  40 a.m., Resident #61's erved by CNA #11 and hooking the Hoyer lift to Resident #61 was lifted nair and transferred to her I body alarm (PBA) from as heard alarming during this same time during an 47 checked the alarm and the "off" position. When need on, the alarm was					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COMP	(X3) DATE SURVEY COMPLETED 07/21/2011		
NAME OF PROVIDER OR SUPPLIER  EDGEWATER WOODS			STREET ADDRESS, CITY, STATE, ZIP CODE  1809 N MADISON AVE ANDERSON, IN46011				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
IAG	On 7/20/11 at 2: interview, LPN; present on the da fractured her hip was receiving he Resident #61 ye when she arrived was found on the bed alarm was or remembered the not the alarm.  2. The record for reviewed on 7/15  Current diagnose limited to, aspiradysphagia, (diffinity history of choking A physician order an order for a put thick liquids both A speech therapt dated 7/14/11 in swallowed safely teaspoon (small pudding thick liquids both and the speech therapt dated 7/14/11 in swallowed safely teaspoon (small pudding thick liquids both and the speech therapt dated 7/14/11 in swallowed safely teaspoon (small pudding thick liquids both and the speech therapt dated 7/14/11 in swallowed safely teaspoon of pure buring observat 7/18/11 at 1:05	55 p.m. during an #13 indicated she was ay Resident #61 fell and of She indicated as she er report, she heard ll out. She indicated did at the room, the resident er floor. She indicated the in the bed, but she only resident yelling out and for Resident # 18 was 8/11 at 5 p.m.  The included, but were not atton syndrome, culty swallowing) and ing.  For dated 7/14/11 indicated areed diet with pudding the via a small spoon.  The y plan of treatment note dicated the resident yelling of quids and 1/4-1/2 spoon utilized) of quids and 1/4-1/2	IAG			DATE	

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NAME OF PROVIDER OR SUPPLIER  EDGEWATER WOODS			STREET ADDRESS, CITY, STATE, ZIP CODE  1809 N MADISON AVE ANDERSON, IN46011				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	p.m., the resident reached his spoot himself his pudd spoon was a regular continued to feed food. He would take bites one after resident began continued to feed was informed the himself with the ADON removed resident and a small was given to the	er meal on 7/18/11 at 6:15 It received his tray. He In and began feeding Ing thick liquids. The Islar dining teaspoon. He Is himself from his puree Is heap the teaspoon and Iter the other. The Islam and began feeding Islam					
F0328 SS=E	proper treatment a special services: Injections; Parenteral and en Colostomy, ureter Tracheostomy car Tracheal suctionin Respiratory care; Foot care; and Prostheses. Based on record interview, the fac oxygen and nebu	review, observation, and cility failed to ensure	F0328	The filing of this plan of corredoes not constitute an admist that the alleged deficiency difact exist. This plan of corre	ssion d in		
	administered in a	manner to prevent		is filed as evidence of the fac	cility's		

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155066 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1809 N MADISON AVE **EDGEWATER WOODS** ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE possible complications and oxygen was desire to comply with the regulatory requirements and to initiated by licensed personnel for 2 of 2 continue to provide quality care. residents reviewed for oxygen The facility does ensure that administration (Resident # 18 and # 62) residents receive proper treatment and care for specialized and failed to ensure PICC (Peripherally services. Corrective action Inserted Central Catheter) was removed in accomplished for those a manner to prevent possible complication residents found to have been for 2 of 3 residents reviewed for PICC affected Regarding Resident lines (Resident # 25 and # 60) in a sample #18, oxygen orders were clarified to indicate liter flow. Regarding of 15. Resident #60, the PICC line was removed and was documented Findings include: that the PICC line was intact. Regarding resident #62, nebulizer cup was rinsed. How the 1. The record for Resident # 18 was facility identified other reviewed on 7/18/11 at 5 p.m. residents having the potential to be affected: Any resident Current physician orders for July 2011 with a PICC line in the past 30 indicated an order for oxygen to be days were reviewed and no residents were negatively administered via a nasal canula to keep affected. Any resident on oxygen oxygen saturations greater than 90 %, no or nebulizer has the potential to liter flow rate was indicated be affected. Systemic Changes the facility made: On 8/2/11, 8/5/11, 8/8/11 and 8/12/11, Staff The July Treatment Administration **Development Coordinator** Record (TAR) for July 2011 lacked provided nursing staff with an oxygen saturation levels. The TAR in-service with post-test regarding indicated the oxygen was set at 2 liters administration of nebulizer treatments to include rinsing the nebulizer before and after the During a transfer observation on 7/18/11 treatment. On 8/2/11, 8/5/11, at 11:30 a.m., Resident # 18 was 8/8/11 and 8/12/11, Staff transferred to his wheelchair. CNA # 8 **Development Coordinator** placed the resident's oxygen tubing on the provided nursing staff with an in-service with post-test regarding portable oxygen tank and turned the liter oxygen therapy and only nurses flow to 2 liters. At that time, during will set the liter flow of oxygen. interview, CNA # 8 indicated as a CNA

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155066	B. WIN			07/21/2	011
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	MADISON AVE		
FDGFW	ATER WOODS			1	SON, IN46011		
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(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	she was able to s	set the liter flow rate of			All residents with oxygen ord will be reviewed for	ers	
	oxygen.				completeness. On 8/2/11,		
					8/5/11, 8/8/11 and 8/12/11, S	taff	
	During interview	v on 7/20/11 at 11:20			Development Coordinator		
	a.m., the Directo	or of Nursing indicated			provided nursing staff with a	า	
		rses should set the flow			in-service on PICC lines to		
	rate of oxygen.	-222 2110 012 200 010 110 11			include documentation of rer		
	late of oxygen.				and obtaining catheter length		
	2.5	1.			How the corrective action	Will	
	2. During a neb				be monitored:		
		LPN # 1 on 7/18/11 at					
		I finished administering			All nurses will be re-educa		
	the nebulizer tre	atment to Resident # 62.			on PICC line removal. All		
	He then placed t	he mask and the			newly hired nurses will be		
	medication conta	ainer in a plastic bag on			educated on PICC line	A 11	
		htstand. He did not rinse			removal during orientation		
	·	r after the treatment.			nurses will be provided wi		
	the cup octore of	atter the treatment.			refresher PICC line remov	aı	
	A 1/20101:	774 - 4 0NT-1 - 11			education ongoing as		
		titled "Nebulizer			residents receive a PICC	ine.	
	I	provided by the Director			How often and for how long	. ill	
	_	20/11 at 8:25 a.m., and			How often and for how long this plan of correction be	WIII	
	deemed as curre	nt. The policy indicated:			monitored? Oxygen therapy	COI	
	"ProcedureC	harge nurse will stay with			will be completed weekly tim		
	resident while tr	eatment is being			four weeks and quarterly		
	delivered, 15. F	Rinse equipment and place			thereafter for at least 6 mont	-	
	back in plastic st	* * *			and if at any time following the		
	ouck in plastic st	toruge oug			issues are identified, the IDT		
	2 The record for	or resident # 25 was			review and determine if furth action is necessary.	er	
					action is necessary.		
	reviewed on 7/19	9/11 at 8:20 a.m.			DNS will be responsible for	or I	
					monitoring. Will the DNS		
	1	er dated 5/4/11 indicated			monitor oxygen therapy or	ı all 📗	
	an order to disco	ontinue the PICC line.			shifts? DNS/Designee wil		
					monitor oxygen therapy or		
	The progress not	tes and TAR for 5/4/11			shifts.	-	
		tation of the removal with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155066		A. BUILDING 00 COMP		(X3) DATE COMPL	ETED		
	PROVIDER OR SUPPLIER	2		1809 N I	DDRESS, CITY, STATE, ZIP CODE MADISON AVE SON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) the catheter and the		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  How often and for how long		(X5) COMPLETION DATE
	intactness of the  On 7/20/11 at 11 information was Director of Nurs assessment of the removal.  On 7/20/11 at 4: Nursing indicate removed the PIC documented at the statement today intact. She indice measurement of  4. The record for reviewed on 7/20  A physician order an order to discording to the p.m., indicated the removed and the measurements of documented.  Additional infortion the Director of the property	:20 a.m., additional requested from the ing regarding the e PICC line after  15 p.m., the Director of d the nurse who had CC line had not ne time, but wrote a that indicated the tip was eated there was no the catheter.  or Resident # 60 was			How often and for how long this plan of correction be monitored? Infection control audit will be completed daily two weeks (5 days per week weekly times four weeks and quarterly thereafter for at least months and if at any time following this, issues are identified; the IDT will review determine if further action is necessary. DNS will be responsible for compliance.  How often will the Quality Assurance Committee be involved in monitoring this procorrection? The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends auditing and staff skills valid and make recommendations further staff development an action.  Will monitoring occur on all shifts? Monitoring will occur shifts.  By what date the system changes will be completed August 20, 2011	CQI times (i), d then est 6  and lan of est of ations for d/or  on all	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	(X3) DATE COME - 07/21/	LETED			
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE  1809 N MADISON AVE  ANDERSON, IN46011					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	by the time of the A policy dated A "Peripherally Inst (PICC) Removal Administrator or and deemed as condicated: "Conurse must be away prior to removal."	formation was provided to final exit on 7/21/11.  August 15, 2008, titled serted Central Catheter I" was provided by the final 7/20/11 at 8:25 a.m., aurrent. The policy onsiderations 1. The ware of the catheter length Improcedure23. Measure and assess catheter tip to be catheter was						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
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			B. WING	_	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				MADISON AVE		
EDGEWA	ATER WOODS				SON, IN46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	$\dashv$	ID		LN	
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	1E	DATE
F0329	Each resident's dr	ug regimen must be free		İ			
SS=D		drugs. An unnecessary					
00 5	drug is any drug when used in excessive dose (including duplicate therapy); or for excessive						
		ıt adequate monitoring; or					
		indications for its use; or in					
		dverse consequences which					
		should be reduced or					
	reasons above.	ny combinations of the					
	reasons above.						
	Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless						
	antipsychotic drug	therapy is necessary to					
		ndition as diagnosed and					
		e clinical record; and					
		antipsychotic drugs receive					
	-	ctions, and behavioral					
		ess clinically contraindicated, ontinue these drugs.					
		ations, interviews, and	F03	220	The filing of this plan of corre	ection	08/20/2011
			100	,,_,	does not constitute an admis		00/20/2011
	-	e facility failed to ensure			that the alleged deficiency di	d in	
		sessed and evaluated for			fact exist. This plan of corre	ction	
	non-medical inte	rventions related to his			is filed as evidence of the fac	cility's	
	anxiety prior to a	administration of an			desire to comply with the		
	anti-anxiety med	ication for 1 of 1 resident			regulatory requirements and		
	reviewed for anx	iety in a sample of 15.			continue to provide quality ca The facility does ensure that		
	(Resident #59)				resident's drug regimen is fre		
	(=1001001101107)				unnecessary drugs. Correct		
	Eindings installa				action accomplished for the		
	Findings include	•			residents found to have be		
					affected Regarding Reside		
		s record was reviewed on			#59, the physician was conta		
	7/18/11 at 4:40 p	.m. The resident's			and an order was received for		
	diagnoses included, but were not limited				psychiatric evaluation and		
to, Alzheimer's disease.		·			treatment for the resident.	How	
	,				the facility identified other		
					residents having the potent	tial	

li ´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
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NAME OF	PROVIDER OR SUPPLIER	}	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
THE OI	I NO VIDER OR SOIT EIEI			1809 N	MADISON AVE		
EDGEW	ATER WOODS		ANDERSON, IN46011				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The undated "So	cial History &			to be affected: All newly		
	Psychosocial Assessment" indicated the				admitted residents will be		
	resident was adn	nitted on 7/02/11. The			reviewed for difficulties in adjustment. Any issues ider	tified	
	"Cognitive/Emo	tional Status/How does			will be communicated to the	itilieu	
	1 -	e?" indicated the resident			attending physician. System	mic	
	1	d anxious. The "Event(s)			Changes the facility made:		
		ement and Reason(s) for			8/2/11, 8/5/11, 8/8/11 and 8/		
	1	* /			Social Services provided an		
		indicated as increased			in-service for all staff member	ers	
		"Mood or behavior's			with post-test on behavior	4-	
		eated as the resident was			management. Any residen identified with symptoms of	เร	
	anxious.				difficulty adjusting, the staff v	will	
					complete a behavior form ar		
	The physician order, dated 7/02/11, was				communicate to the charge i		
	Lorazepam (Ativ	van) (anti-anxiety) 0.5			and social services. A care		
		1 tables 3 times a day as			will be developed with		
	needed.	i tuores s times u uuy us			interventions to address the		
	needed.				behavior. This will be	a tha	
	TI. "MEDICAT	NON			communicated to the staff vi CNA assignment sheet and		
	The "MEDICAT				plan. Any new or worsening		
		TION RECORD (MAR)"			behaviors will be reviewed b		
	for 7/2011 indica	ated the following:			IDT and care plan will be rev		
					as indicated. Social Services		
	Lorazepam (Ativ	van) 0.5 milligrams was			work with all new admissions		
	indicated as give	en in this order on the			assist in the adjustment prod		
	back of the MAI	R as follows: On 7/06 at			On 8/2/11, 8/5/11, 8/8/11 ar 8/12/11, Staff Development	iu	
		at 4 p.m.; on 7/09 at 6:			Coordinator provided Licens	ed	
	1 -	on 7/10 at 2:15 p.m.; on			nurses an inservice with pos		
	1	ar); on 7/15 at 7:50 p.m.;			on documentation of PRN		
	`				psychotropic medications an	ıd	
	1	.; on 7/04 at 5 p.m.; on			non-medical interventions w		
	_	n 7/11 at 6 p.m.; on 7/14			provided prior to administrati	on of	
	1 * '	7 at 6 p.m.; and on 7/18			psychotropic medications.	aduet	
		ne reason listed for all of		Pharmacy consultant will conduct a full-house audit to determine all			
	the above medication administration was				drugs are necessary.	io uii	
	"anxiety." The r	results were all indicated			How the corrective action	will	
	as effective.				be monitored:		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155066 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1809 N MADISON AVE **EDGEWATER WOODS** ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE How often and for how long will The "Resident Progress Notes" indicated this plan of correction be the following: monitored? Behavior management/unnecessary drug On 7/02/11 at 4:00 p.m., the resident was CQI will be completed weekly times four weeks, monthly times admitted to the facility. He was indicated three months and then quarterly as alert and confused, moderately anxious thereafter for at least 6 months at times, and is forgetful. and if at any time following this, On 7/04/11 at 11:21 a.m., the resident was issues are identified, the IDT will review and determine if further restless and agitated. He was action is necessary. continuously asking to go home and leave. The resident stated he was left here Social Services Director will be and was being held. The resident was responsible for compliance. redirected numerous times which were Will monitoring occur on all unsuccessful, and Ativan (anti-anxiety) shifts? Monitoring will occur on medication was given. The resident did day and evening shifts. calm down. On 7/05/11 at 11:40 p.m., the resident was How often will the Quality Assurance Committee be indicated as alert but very confused, and involved in monitoring this plan of "anxious at times," with Ativan given at correction? The Quality 6:00 p.m. "with some relief." Assurance Committee (CQI On 7/10/11 at 2:15 p.m., the resident was Committee) will meet at least monthly to review the trends of sitting in the hallway looking around and auditing and staff skills validations interacting with staff with no further and make recommendations for complaints. He was medicated for further staff development and/or anxiety. On 7/17/11 at 6:00 p.m., the resident was By what date the systemic changes will be completed: indicated as mildly to moderately anxious August 20, 2011 and was medicated per physician's orders. No further information was indicated regarding the use of non-medical interventions prior to the medication administration of Lorazepam (Ativan).

PRINTED: 08/23/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066		(X2) MULTIPLE CC  A. BUILDING  B. WING	NSTRUCTION 00	li i	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIEF	2	1809 N	ADDRESS, CITY, STATE, ZIP COI MADISON AVE SON, IN46011	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	was observed in dining room awa inquiring where doing her, and w people" as break being completed  On 7/20/11 at 10 was observed in hallway by the n heard to be askir these people were  On 7/21/11 at 8: interview, the Dindicated the star Resident #59's q  On 7/21/11 at 9:: Director indicate to go to activitie evaluated concer same time during indicated a physical properties of the star o	his wheelchair in the urse's station. He was and who he in the hallway.  45 a.m. during an arector of Nursing (DON) off did stop and answer uestions.  50 a.m., the Activity had the resident was asked as and was presently being ming 1 to 1 visits. At this ag an interview, the DON dician order was received sychiatric services to				

000026

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155066 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1809 N MADISON AVE **EDGEWATER WOODS** ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Menus must meet the nutritional needs of F0363 residents in accordance with the SS=E recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. The filing of this plan of correction Based on observation, interview and F0363 08/20/2011 does not constitute an admission record review, the facility failed to ensure that the alleged deficiency did in pureed menus were followed for 2 of 2 fact exist. This plan of correction residents reviewed for pureed diets in a is filed as evidence of the facility's desire to comply with the sample of 15 (Residents #46 & #53) and 2 regulatory requirements and to of 2 residents reviewed for following continue to provide quality care. pureed menus in a supplemental sample The facility does provide menus of 6 (Residents #52 and #37). This that meet the nutritional needs of deficient practice had the potential to the residents. Corrective action accomplished for those impact the 19 residents with physician's residents found to have been orders for pureed diets. affected Regarding Residents 52, 46, 37 and 53, the residents Findings include: were served two ounces of pureed cottage cheese and one extra portion of bread sticks to 1.) Resident #52's record was reviewed correct the serving size. How on 7/20/22 at 10:15 a.m. the facility identified other residents having the potential Resident #52's current diagnoses included. to be affected: All residents on a pureed diet had the potential to but were not limited to, Huntington's be affected and were provided chorea, speech disorder, and dysphasia. the cottage cheese and breadsticks to correct the serving. Resident #52 had a current, 4/1/11, Systemic Changes the facility made: On 8/15/11, the physician's order for a pureed diet. Registered Dietician will re-inservice Dietary staff with 2.) Resident #46's record was reviewed return-demonstration on portion on 7/18/11 at 10:50 a.m. sizes during meals and preparation of pureed food. All new dietary staff will be educated Resident #46's current diagnoses included, on portion sizes and preparation but were not limited to, mental

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155066	B. WIN	IG		07/21/2	011
NAME OF	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER			1809 N	MADISON AVE		
	ATER WOODS				SON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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	retardation, spee	ech disorder, and			of mechanically altered diets Dietary manager will oversee		
	depression.				tray line to ensure portion siz		
					are accurate. How the corre		
	Resident #46 had	d a current, 1/10/11,			action will be monitored: Ho		
	physician's order	r for a pureed diet.			often and for how long will th		
	-	_			plan of correction be monitor		
	3) Resident #37	7's record was reviewed			Meal observation/preparation		
	on 7/20/11 at 9:1				tool will be completed daily ( days per week) times two we		
	on 7/20/11 at 3.1	u.m.			at every meal, weekly times		
	Danisland #271a a				weeks and then quarterly	ioui	
		urrent diagnoses included,			thereafter for at least 6 mont	hs	
	but were not limited to, mental				and if at any time following th	nis,	
	retardation, mental retardation, and				issues are identified, the IDT		
	depression.				review and determine if furth		
					action is necessary. Dietar	у	
	Resident #37 had	d a current, 7/22/10,			Services Manager will be responsible for monitoring. \	۸/۱۱۱	
	physician's order	r for a pureed diet.			the Dietary Services Manage		
		•			monitor all three meals? Die		
	4) Resident #53	3's record was reviewed			Services Manager/Designee		
	on 7/18/11 at 10					ow	
	011 // 10/ 11 at 10	.43 a.m.			often will the Quality Assurar	nce	
	D :1 / ////21				Committee be involved in		
		urrent diagnoses included,			monitoring this plan of correction? The Quality		
	but were not lim	<i>'</i>			Assurance Committee (CQI		
	retardation, legal	lly blind and dysphasia.			Committee) will meet at leas	t	
					monthly to review the trends	of	
	Resident #53 had	d a current, 12/14/10,			auditing and staff skills valida		
	physician's order	r for a pureed diet.			and make recommendations		
					further staff development and		
	5.) Review of a	menu/spreadsheet for			action. Will monitoring occu all shifts? Monitoring will occ		
		st, which was provided by			with all three meals. By wh		
	•	es Supervisor on 7/18/11			date the systemic changes		
	1	icated residents with			be completed: August 20,		
		re menued to receive 3/8					
	1 ^						
	1 * `	pureed sausage gravy					
	$\int$ and 5 and $1/3$ tal	blespoon (3 ounces)of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066		(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION 00	(X3) DATE COMP - 07/21/2	LETED	
	PROVIDER OR SUPPLIER	<b></b>	1809 N	DDRESS, CITY, STATE, ZIP COI MADISON AVE SON, IN46011	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	pureed biscuits.  6.) During a 7/1 a.m., breakfast o #52, #46, #37 an cup (2.7 ounce) p gravy and biscuit together. This p the menued amo  During a 7/19/11 Cook #14 indica pureed sausage g together and was cup portion of th  During a 7/19/11 Food Services So portion of pureed biscuits was a po small a serving, would be address items at a later m	9/11, 8:05 a.m. to 8:20 bservation, Residents d #53 were served a 1/3 portion of pureed sausage ts which were mixed ortion was smaller than unt.  , 8:20 a.m. interview ted he had prepared the gravy and biscuits a serving a #12 scoop/ 1/3 e mixed food product.  , 8:21 a.m., interview the upervisor indicated the d sausage gravy and ortion size error and too She indicated the error sed by serving additional		CROSS-REFERENCED TO THE AP		
	the Food Service the error from th breakfast would ounces of pureed	es Supervisor indicated e pureed sausage at be corrected by serving 2 d cottage cheese and 1 breadsticks during the				
	l ′	n undated, form titled idents by Diet", which				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155066 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1809 N MADISON AVE **EDGEWATER WOODS** ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
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CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE was provided by the Administrator on 7/19/11 at 10:55 a.m., indicated 19 current residents had physician's orders for a pureed diet. 3.1-20(i)(1)3.1-20(i)(4)F0365 Each resident receives and the facility provides food prepared in a form designed to SS=E meet individual needs. The filing of this plan of correction F0365 08/20/2011 Based on observation, interview and does not constitute an admission record review, the facility failed to ensure that the alleged deficiency did in residents who had physician's orders for a fact exist. This plan of correction mechanical soft diet, were served food in is filed as evidence of the facility's desire to comply with the a mechanical soft form for 1 of 1 resident regulatory requirements and to in a sample of 15 reviewed for mechanical continue to provide quality care. soft diets as ordered (Resident #42) and 3 The facility does provide food of 3 residents in a supplemental sample of prepared in a form designed for 6 reviewed for mechanical soft diets as the individual needs of residents. **Corrective action** ordered (Residents #51, #48 and #38). accomplished for those This deficient practice had the potential to residents found to have been impact the 10 residents who had affected Regarding Residents physician's orders for a mechanical soft 42, 51, 48, 38, the lettuce and tomato were removed from the diet. tray prior to consumption. How the facility identified other Findings include: residents having the potential to be affected: All other mechanical soft diet trays were checked and lettuce and tomato Review of the current, facility, were removed and replaced with menu/spreadsheet for the 7/18/11 lunch, tomato juice per menu. which was provided by the food services Systemic Changes the facility supervisor on 7/19/11 at 9:45 a.m., made: On 8/15/11, the Registered Dietician will indicated resident's with orders for a re-inservice Dietary staff with

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li '		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155066	B. WING			07/21/2	011
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹		1809 N	MADISON AVE		
EDGEW	ATER WOODS				SON, IN46011		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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	mechanical soft	diet could not have fresh			return-demonstration on serv	/ing	
	tomatoes and let	tuce and were menued to			and preparation of specialty		
	have tomato juic	e in it's place			diets. On 8/2/11, 8/5/11, 8/		
	liave tolliate jule	is in its place.			and 8/12/11, Staff Developm		
	1 ) Danidana #40	No d			Coordinator in-serviced nurs staff with post-test on serving	-	
	I '	2's record was reviewed			meals to ensure appropriate		
	on 7/18/11 at 11	:00 a.m.			The Dietary manager will	uict.	
					oversee the tray line to ensu	re	
	Resident #42's c	urrent diagnoses included,			diet consistencies are accura		
	but were not lim	ited to, history of head			How the corrective action wil	l be	
	injury, mental re	, ,			monitored: How often and f	or	
	hypertension.	turum uru			how long will this plan of		
	hypertension.				correction be monitored? Me		
					observation/preparation CQI		
	Resident #42 had				will be completed daily (5 da		
	physician's order	r, which originated			per week) times two weeks a		
	8/27/10, for a me	echanical soft diet.			every meal, weekly times for weeks and then quarterly	וג	
					thereafter for at least 6 mont	hs	
	Resident #42 had	d a current 4/21/11,			and if at any time following the		
		num Data Set Assessment,			issues are identified, the IDT		
	1 *				review and determine if furth	er	
	1	he needed a mechanically			action is necessary. Dietar	y	
	altered diet.				Services Manager will be		
					responsible for monitoring. V		
	Resident #42 had	d a current 11/23/10 care			the Dietary Services Manage		
	plan problem/ne	ed regarding a risk for			monitor all three meals? Die	,	
	1 * *	oproach to this problem			Services Manager/Designee monitor all three meals. Ho		
	was to serve the	•			often will the Quality Assurar		
	was to serve the	aict as oracica.			Committee be involved in		
	2) D. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.				monitoring this plan of		
	'	I's record was reviewed			correction? The Quality		
	on 7/20/11 at 10	:00 a.m.			Assurance Committee (CQI		
					Committee) will meet at leas		
	Resident #51's c	urrent diagnoses included,			monthly to review the trends		
	1	ited to, depression,	auditing and staff skills validations				
		on and speech disorder.			and make recommendations		
		and speech disorder.			further staff development and		
	D :1 : "51.1	1 2/0/11			action. Will monitoring occu all shifts? Monitoring will occ		
	I Kesident #51 had	d a current, 2/2/11,	ı	l	an arms: Mornioring will occ	uı	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	д ріп	LDING	00	COMPLETED
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EDGEWA	ATER WOODS			ANDER	SON, IN46011	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	physician's order	for a mechanical soft			with all three meals. By wh	at
	diet.	Tor a modulation sort			date the systemic changes	•
	ulet.				be completed: August 20,	•
	Resident #51 had a current 5/4/11,					
	quarterly, Minim	num Data Set Assessment,				
	which indicated	she required a				
	mechanically alt	•				
	incomanically all	orda aret.				
	D 11	1 0/16/11				
		d a current, 2/16/11,				
	problem/need reg	garding a potential for				
	aspiration. An a	pproach to this problem				
	was to serve the	diet as ordered.				
	2) Dagidant #49	B's record was reviewed				
	·					
	on 7/20/11 at 9:4	5 a.m.				
	Resident #48's cu	urrent diagnoses included,				
	but were not lim	ited to,mental retardation,				
	anxiety, and hyp					
	anxiety, and hyp	ertension.				
	D 11 / //401	1 2/0/11				
		d a current, 2/8/11,				
	physician's order	for a mechanical soft				
	diet.					
	Resident #48 had	d a current, 5/5/11,				
		num Data Set Assessment,				
		the resident required a				
	mechanically alt	ered diet.				
	4.) Resident #38	B's record was reviewed				
	on 7/20/11 at 9:3					
	011 //20/11 at 9.5	v u.iii.				
		urrent diagnoses included,				
	but were not lim	ited to, mild mental				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066		(X2) MULTIPLE ( A. BUILDING B. WING	00	COMP	COMPLETED 07/21/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1809 N MADISON AVE  ANDERSON, IN46011			
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	retardation and c Resident #38 had physician's order diet.  Resident #38 had plan problem reg chocking. An apwas to serve a di 5.) During a 7/1 p.m., lunch meal #42, #51, #48 an physician's order diet as indicated fresh tomatoes and During a 7/18/11 the Food Service residents with meshould not receival lettuce and those error.  Review of an und "Number of Resi was provided by 7/19/11 at 10:55	da current, 11/1/10, for a mechanical soft  If a current, 11/24/10 care garding a risk for approach to this problem et as ordered.  8/11, 12:18 p.m. to 12:50 observation, Residents d #38, who had so for a mechanical soft above, were all served and lettuce.  12:50 p.m., interview some supervisor indicated echanical soft diets are fresh tomatoes and items had been served in dated, form titled dents by Diet", which the Administrator on a.m., indicated 10 current associan's orders for a				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155066		(X2) MU A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE S COMPL <b>07/21/2</b>	ETED	
	PROVIDER OR SUPPLIER			1809 N N	DDRESS, CITY, STATE, ZIP CODE MADISON AVE SON, IN46011		
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F0425 SS=E	residents, or obtai described in §483 facility may permit administer drugs it under the general nurse.  A facility must provise (including accurate acquiring administering of almeet the needs of The facility must e of a licensed pharmacy services Based on record interview, the facility pharmacy service ensure a new phy communicated to residents reviewed (Resident # 25) a medications were administration for reviewed for medications were sample of 15. (Rand # 57)  Findings include	and biologicals to its in them under an agreement in the unlicensed personnel to if State law permits, but only is supervision of a licensed  in the procedures that assure the interpretation of the provision of the provis	F04	125	The filing of this plan of corredoes not constitute an admis that the alleged deficiency diffact exist. This plan of correctis filed as evidence of the fact desire to comply with the regulatory requirements and continue to provide quality can the facility does provide rout and emergency drugs to the residents as ordered by the physician. Corrective actionaccomplished for those residents found to have been affected. Regarding Resider 25, 28, 22 and 57, all medications were located or provided for residents. How the facility identified other residents having the potential to be	sion d in ction cility's to are. cine n en nts ttions	08/20/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 775111

Facility ID:

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If continuation sheet

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A BUILDING B. WING 00 COMPLETED 07/21/2011  NAME OF PROVIDER OR SUPPLIER  EDGEWATER WOODS  (X4) ID PROVIDERS PLAN OF CORRECTION MADISON AVE 1809 N	
NAME OF PROVIDER OR SUPPLIER  EDGEWATER WOODS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  During a medication pass observation with LPN # 1, on 7/19/11 at 9:45 a.m., the resident was administered an oxycodone 5 milligram tab. During reconciliation of the medication pass, the physician order on the July orders was for oxycodone 5 milligrams 2 tabs as needed every 2 hours for pain. The original date of this order was 6/4/11. At 11 a.m., the Director of Nursing was queried regarding the order for the oxycodone. At that time during interview, she indicated the physician had  SUMMADISON AVE ANDERSON, IN46011  PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPLIATED TO CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  PREFIX (EACH ORRICTIVE ACTION SHOULD BE COMPLIATED TO C	
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ANDERSON, IN46011  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  During a medication pass observation with LPN # 1, on 7/19/11 at 9:45 a.m., the resident was administered an oxycodone 5 milligram tab. During reconciliation of the medication pass, the physician order on the July orders was for oxycodone 5 milligrams 2 tabs as needed every 2 hours for pain. The original date of this order was 6/4/11. At 11 a.m., the Director of Nursing was queried regarding the order for the oxycodone. At that time during interview, she indicated the physician had  ANDERSON, IN46011  ID PREFIX (EACH OERICTIVE ACTION SHOULD BE COMPLIA COMPLIA (COMPLIA COMPLIA) (COMPLIA (COMPLIA COMPLIA) (COMPLIA COMPLIA COMPLIA) (COMPLIA COMPLIA COMPLIA COMPLIA (COMPLIA COMPLIA COMPLIA COMPLIA COMPLIA (COMPLIA COMPLIA COMPLIA COMPLIA COMPLIA COMPLIA (COMPLIA COMPLIA COMPLIA COMPLIA COMPLIA COMPLIA (COMPLIA COMPLIA CO	
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sent a script directly to the pharmacy for the oxycodone 5 milligrams 2 tabs without notifying the facility. During interview on 7/19/11 at 12:45 p.m., the Director of Nursing indicated the pharmacy had failed to notify the facility of the medication change. The July Medication Administration Record (MAR) reflected the order for 5 milligrams 2 tabs. The back of the July MAR indicated the resident received one tab on 7/6/11 at 6 a.m., 7/12/11 at 12:30 p.m., and 7/19/11 at 9:45 a.m  Current physician orders for July 2011 indicated an order for Lyrica 150 milligrams to be given twice daily.  The MAR for July 2011 indicated the Lyrica was unavailable on 7/7/11-7/9/11, for 6 doses.  How the corrective action will be monitored:  How often and for how long will this plan of correction be monitored? Facility will complete an audit at least quarterly to review carts for availability of medications. Pharmacy will complete an audit at least quarterly to review carts for availability of medications. Discrepancies will be resported to the DNS. This plan of correction will be monitored for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary.  The DNS/Designee will be responsible to monitor. Will monitoring occur on all shifts? Monitoring will occur on all	IE .

li ´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING 00		COMPLETED	
		155066	B. WIN			07/21/2011	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
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	ATER WOODS			ANDER	SON, IN46011		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
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	A FAX 1	4			Silits.		
		t was provided by the			How often will the Quality		
	Administrator on 7/21/11 at 11 a.m. The				Assurance Committee be		
		ted the Lyrica had been			involved in monitoring this pl	an of	
		1 and 7/8/11. The Lyrica			correction? The Quality		
	arrived on 7/9/11				Assurance Committee (CQI Committee) will meet at leas	.	
	2. The record for Resident # 28 was				monthly to review the trends	<b> </b>	
					auditing and staff skills valida	ations	
	reviewed on 7/20	0/11 at 10:40 a.m.		for d/or			
	Current physician orders for July 2011				action.		
	indicated an order for Allegra 180 milligrams daily. Original date of the				By what date the systemic	<b> </b>	
					changes will be completed: August 20, 2011		
	order was 2/10/1	•			7.agust 20, 2011		
	The June 2011 M	IAR indicated the Allegra					
		on 6/20/11 and 6/21/11.					
	During interview	on 7/21/11 at 9:50 a.m.,					
	_	ursing indicated the					
		sed 2 doses of the					
	Allegra.						
	<i></i>						
	3. The record for	r Resident # 22 was					
	reviewed on 7/18						
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	Physician orders	for July 2011 indicated					
	1 -	min D 50,000 units to be					
		riginal date of the order					
	was 10/27/10.	5 m 5 m 5 m 6 m 6 m 6 m 6 m 6 m 6 m 6 m					
	The May 2011 M	IAR indicated the					
	Vitamin D was u						
		n 5/2/11, 5/16/11 and					
						<u> </u>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155066		(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER	<b>!</b>	1809 N	ADDRESS, CITY, STATE, ZIP CO MADISON AVE RSON, IN46011	DDE	
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	the Director of N Vitamin D had to month and had n 4. Resident #57' 7/18/11 at 5:20 p diagnoses include to, hyperlipidem  The physician's 66/24/11 and sign Simvastatin 20 m bedtime for hyper the "MEDICAT ADMINISTRAT 7/2011 indicated Simvastatin was administration or 7/08, 7/09, and 7 On 7/21/11 at 12 interview, the Director of the phasent her an author out for Resident Simvastatin, who she also indicated authorization for	s record was reviewed on o.m. The resident's ed, but were not limited ia.  order, originally dated ed 7/13/11, was nilligram 1 tablet orally at erlipidemia.  ION TION RECORD" for the medication, unavailable for n 7/03, 7/04, 7/06, 7/07,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066			(X2) MULTIPLE CC  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE COMP 07/21/2	LETED		
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	PROVIDER OR SUPPLIER		1809 N	ADDRESS, CITY, STATE, ZIP CODE MADISON AVE RSON, IN46011							
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  PEGLI ATORY OF LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PERCEDED BY FULL		(EACH DEFICIENCY MUST BE PERCEDED BY FULL		(EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
F0441 SS=E	The facility must en Infection Control F a safe, sanitary and and to help prever transmission of discontrol of the Infection Control of the Infection Control of the Infection Control of the Infection of Infect	establish an Infection Control nich it - controls, and prevents cility; crocedures, such as e applied to an individual cord of incidents and related to infections.  read of Infection ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin t contact with residents or contact will transmit the  st require staff to wash their direct resident contact for ng is indicated by accepted	TAG	DEFICIENCY)	DATE						
	transport linens so infection. Based on observa	andle, store, process and as to prevent the spread of ations, interview, and are facility failed to ensure	ns, interview, and F0441 The filing of this plan of cor								
	infection control in a manner to pr	practices were followed revent the potential for ections and diseases		that the alleged deficiency di fact exist. This plan of corre is filed as evidence of the fact desire to comply with the	ction						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155066	B. WIN	IG		07/21/2	011
NAME OF	PROVIDER OR SUPPLIER	3	•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
				1	MADISON AVE		
EDGEW	ATER WOODS			ANDERSON, IN46011			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	<b>†</b>	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		washing and glove use			regulatory requirements and continue to provide quality ca		
	for 4 of 5 CNAs	(CNA#s 4, 5, 11, and 12)			The facility does establish ar		
	observed for 1 of 2 residents (Resident				maintain an infection control		
	#61) during personal care/transfers,				program designed to provide	a	
	concerning meal	trays being passed for 3			safe, sanitary and comfortab		
	of 8 residents (Resident #'s 59, 61, and				environment. Corrective ac	tion	
	63) observed for 5 of 7 staff members (RN #6, LPN #1, Physical Therapist #9, and CNA #'s 4 and 10), concerning linen handling for 1 of 1 laundry aide (Laundry Aide #15) for 1 of 1 observation in the laundry, and concerning medication pass				accomplished for those	. n	
					residents found to have been affected: Residents #61 an		
					#65 were not affected. CNA		
					and CNA #5 were re-inservice		
					on hand washing. Regardin		
					#6, there was no resident or	food	
	for 2 of 7 nursing staff (LPN #1 and RN				contact cited. RN #6 was re-inserviced on hand washii	20	
		esidents (Resident #'s 28,			Regarding resident #59, LPN		
	l '	·			was re-inserviced on hand		
	1	rved during medication			washing and tray/meal service	ce.	
	1 *	ning a dressing change			Regarding resident #63, CNA		
		nt (Resident #18)			re-inserviced on hand washi	•	
		f 1 dressing change			LPN #10, LPN #1, Laundry A #15, CNA #10, CNA #11, CN		
	observed.				#12 and PT #9 were re-inser		
					on hand washing. RN#3 wa	ıs	
	Findings include	<b>:</b>			re-inserviced on medication	set	
					up. Resident #60 was not	-4	
	1. On 7/18/11 fr	rom 11:05 a.m. to 11:40			affected. Regarding reside #25. an assessment of the	nt	
	a.m., Resident #	61's transfer and personal			resident's eye was complete	d and	
	care was observe	ed. Upon entering CNA			there are no symptoms of		
	#4 was observed	to handwash for less			infection. How the facility		
	than 15 seconds	and donned a pair of			identified other residents		
	gloves. CNA #4	and CNA #5 hooked the			having the potential to be		
	Hoyer lift to the	Hoyer sling the resident			affected: An infection surveillance report was		
	was sitting on in the wheelchair. Next, as				completed to identify trends	and	
	CNA #4 attempted to operate the Hoyer				clusters of infections and the		
	lift without success, she indicated the				were no issues identified.		
		I. CNA #5 removed her			Systemic Changes the facil		
	gloves, left the r				<b>made:</b> On 8/2/11, 8/5/11, 8/	8/11	
	gloves, left the r	oom with no					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155066	A. BUI	LDING	00	07/21/2	
		193000	B. WIN			0772172	011
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
EDOE!W	ATED WOODS			1	MADISON AVE		
	ATER WOODS			ANDER	SON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)	-	TAG	•		DATE
		ndgel use, and returned			and 8/12/11, Staff Developm Coordinator provided facility		
		ry for the Hoyer lift.			an in-service with post-test a		
	Resident #61 was then transferred from				return demonstration regardi		
	her wheelchair to the bed. After the				hand washing and glove usa	ge	
	resident's person	nal care was completed,			pertaining to meal service,		
	with the same gloves CNA #4 checked both of her uniform pockets and retrieved a plastic bag and bagged the brief. With the same gloves the resident's bed was				administration of medications dressing changes. Skills	s and	
					validations for hand washing		
					glove usage, medication	,	
					administration and dressing		
	repositioned up against the wall, then,				changes will be completed o		
	CNA #4 removed her gloves and with the				licensed nurses by 8/20/11.	,	
	bed remote elevated the resident's head of				resident identified with a pote infection will have a surveilla		
	bed before she was observed to handwash.				investigation completed. All	1100	
		e during an interview,			nosocomial infections will be		
	1	ed one should handwash			investigated for trends, an		
		nd before and after			infection rate will be determine		
	resident care.	nd before and after			and a plan will be developed address the trends for any is		
	resident care.				identified.	sues	
	2 0 7/10/11 6	12.15 1.00			How the corrective action	will	
		rom 12:15 p.m. to 1:00			be monitored:		
	_	observed in the Moving					
	1	room. The following was			How often and for how long	will	
	observed:				this plan of correction be		
					monitored? An infection cont		
		rved to handwash, turn			CQI will be completed daily ( days per week) for two week		
	the water off wit	th her wet hand, and then,			weekly times four weeks and		
	dried her hands.	She was then observed			quarterly thereafter for at lea		
	to obtain the mil	k pitcher as drinks were			months and if at any time		
	being prepared.	After passing several			following this, issues are	ond	
	meal trays, RN #	#6 was again observed to			identified, the IDT will review determine if further action is	anu	
	handwash, turn the water off with her wet		necessary. An infection				
	hand, and then, dried her hands. She then proceeded to obtain a straw for Resident #61 as she was observed to use the straw				surveillance report will be		
					completed monthly and evalu	uated	
					for any clusters or trends.		
	in her orange dri						
	I in her orange un	IIIK,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155066 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1809 N MADISON AVE **EDGEWATER WOODS** ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The DNS/Designee will be responsible for the LPN #7 was observed to cut Resident coordination of monitoring and #59's egg salad sandwich in half. With compliance. the egg salad observed on her hands, LPN #7 was observed to wet her hands and dry Will the infection control CQI/DNS them as she left the dining room. monitoring occur on all shifts? The infection control Resident #59 was observed to be eating CQI/DNS/Designee will monitor his egg salad sandwich. on all shifts. CNA #4 was observed to pick up soiled How often will the Quality dishes, handwashed for less than 15 Assurance Committee be involved in monitoring this plan of seconds, and then, serve Resident #63 his correction? The Quality substitution for the meal removing the lid. Assurance Committee (CQI Committee) will meet at least 3. On 7/18/11 from 5:25 p.m. to 6:05 monthly to review the trends of auditing and staff skills validations p.m., dinner was observed in the Moving and make recommendations for Forward dining room. As staff entered to further staff development and/or assist with passing meal trays, LPN #7 action. was observed to handwash, turn the water off with her wet hands, and then dried her By what date the systemic changes will be completed: hands. Also, Physical Therapist #9 was August 20, 2011 observed to handwash for less than 20 seconds as she passed meal trays. CNA #10 was observed to handwash for less than 15 seconds as she was observed to pass the drinks/meal trays. 4. On 7/19/11 at 8:40 a.m., Resident #61's transfer from her wheelchair to her bed for a change of clothes were observed. After the transfer and change in clothing had been completed, CNA #11 was observed to leave the room, obtain a lap cover from the linen closet on this

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 07/21/2	LETED	
	PROVIDER OR SUPPLIEF	<b></b>	1809 N	ADDRESS, CITY, STATE, ZIP COI I MADISON AVE RSON, IN46011	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	where the lap co resident's legs. I Resident #65's ro	ver was put over the Next, CNA #11 entered boom to check on him.				
		om 9:10 a.m. to 9:50 61's personal care was				
	urine and a large liquid stool. As hands did the res brown BM (bow observed on the and also a small hand. CNA #12 donned a new pa	had been incontinent of amount of dark brown CNA #12 with gloved sident's front peri-care, sel movement) was washcloth with each wipe amount on her gloved removed her gloves and hir of gloves. No ndgel use was observed.				
	CNA #12 compl front peri-area. turned and as the cleansed, an ope buttocks was observed her glo handwashing/hat When CNA #12 was observed to	eted cleaning around the After the resident was e rectal area was being in area on the resident's served. CNA #12 ves and left the room. No indgel use was observed. returned to the room, she handwash for 15 seconds to the personal care, which the resident was				
	b.) As CNA #11	and CNA #12 with mpleted the personal care				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE COMP	SURVEY LETED	
		155066	A. BUILDING B. WING		07/21/2	2011
				ADDRESS, CITY, STATE, ZIP COD	DE	
NAME OF I	PROVIDER OR SUPPLIER		l l	MADISON AVE		
EDGEW	ATER WOODS		ANDEF	RSON, IN46011		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUNDS CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	COMPLETION DATE
IAG		CNA #11 removed the	IAG	BERIODINE TY		DATE
	towel with incon					
		om in front of the				
		and bagged it. CNA #11				
	_	al area of incontinent				
	BM, changed glo					
	-	ndgel use observed, and				
		eansing of the rectal area.				
	Both CNAs with	_				
		osition the resident in her				
		low under her head before				
	they removed the					
	· ·	t this same time during an				
		#11 indicated one should				
		seconds. She also				
		ould handwash after				
		ent during personal care				
	1	fter any care with a				
	resident.					
		om 1:15 p.m. to 2:50				
	p.m., the environ					
		e laundry room, Laundry				
	1	oved hands was observed				
	_	running water over a sink				
		ontaining fecal material.				
	1 -	vering was observed over				
		apron with a plastic-like				
	I -	served folded on a shelf				
	1	om. Laundry Aide #15				
		th the same gloves to turn				
	· ·	te a paper towel and				
	_	f perspiration, removed				
	her gloves and ol	btained another paper				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155066		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	li i	e survey pleted /2011	
	PROVIDER OR SUPPLIER		STREET 1809 N	ADDRESS, CITY, STATE, ZIP C I MADISON AVE RSON, IN46011	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	she was instructed then proceeded to this same time do indicated she did covering while so soiled and clean time during an in Housekeeping So should be worn to soiled linen.  7. During a med 7/18/11 at 11:45 LPN entered Respushed up the resinjected insuling the resinjected insuling to the medication medication book his pocket.  8. During a med on 7/18/11 at 4:4 RN, while setting Resident # 60, position into the medication into the medication administered the 60.  9. During a med on 9. During a med on 9. During a med on 9.	ication pass observation a.m., with LPN # 1, the ident # 28's room. He sident's sleeve and without wearing gloves. In the LPN exited the shing his hands and went a cart, documented in the and placed his ink pen in ication pass observation 5 p.m., with RN # 3, the g up medication for opped the Coumadin 2 his hand, then placed it on cup. The RN then medication pass observation				
		.m., with LPN # 1, LPN # t # 25's eye drop bottle				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  OO COMPLETED					
ANDILAN	OI CORRECTION	155066		BUILDING			07/21/2	
		1.55555	B. V	VING	DDDEGG CVWV CWV	TE ZID CODE	01,21,2	· · ·
NAME OF P	PROVIDER OR SUPPLIER	2		1	DDRESS, CITY, STA MADISON AVE	I E, ZIP CODE		
   EDGEW/	ATER WOODS			1	SON, IN46011			
(X4) ID		STATEMENT OF DEFICIENCIES		ID				(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE	LAN OF CORRECTION E ACTION SHOULD BE	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		D TO THE APPROPRIAT CIENCY)	E	DATE
	into his shirt unit	form pocket. He then						
	washed his hands and went the Resident							
	at the dining room	m table and removed the						
	eye drop bottle fi	rom his pocket and						
	administered the	eye drops without						
	donning gloves.	He used his ungloved						
	hand to hold the eyes open for the							
	instillation of the drops. He then placed							
	the eye drop bott	tle in his uniform pocket						
	and then placed t	them back in the						
	medication cart.							
	10. The record for Resident # 18 was							
	reviewed on 7/18	8/11 at 5 p.m.						
		•						
	Current July orde	ers indicated an order to						
	1	rea on the right inner						
	_	klenz spray prior to						
	treatment.	1 3 1						
	During a wound	care observation on						
	7/19/11 at 10:50	a.m., LPN # 1 removed						
		ng from Resident # 18's						
		shing his hand and						
		oves, LPN # 1 applied the						
		ing. He did not clean the						
	_	pplying the clean						
		g interview at the end of						
		nge, LPN # 1 indicated he						
		ailed to clean the wound						
		the dressing change.						
		ar toom o thunge.						
	   11   Policies date	ed July 2008 and titled						
		'Linen and Laundry", was						
FORM CMS-2	2567(02-99) Previous Version	·	77511	1 Facility II	D: 000026	If continuation sh	neet Do	ge 63 of 66

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			X3) DATE : COMPL <b>07/21/2</b>	ETED	
	PROVIDER OR SUPPLIER		F	STREET AD	DDRESS, CITY, STAT MADISON AVE SON, IN46011	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		Ē	(X5) COMPLETION DATE	
TAG	provided by the at 8:25 a.m., and "Laundry" policy laundry is consider Handle soiled liminursing unit with agitation/shaking utility gloves or aprons when sort loading into was are removed, and clean linen is removed, and clean linen is removed. The soft infection of infection	Administrator on 7/20/11 deemed as current. The vindicated "ALL lered contaminated. 2. ten, clothing on the a a minimum of gc. Laundry staff wear disposable gloves and ting ALL linen for hers. Gloves and apron hands are washed before noved from the washer e dryer" The "Linen licy indicated: dle, store, process and o as to prevent the spread Soiled linenContainers l, plastic carts/bins with tted lids"  2010 and titled ministration", ttaneous Procedure", "Eye re", and " Dressing and Procedure" was Administrator on 7/20/11 deemed as current. The ministration" policy Medications will be contaminating" The ttaneous Procedure" Prepare medication4.		IAG	DEFR	(EENCT)		DATE
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	775111	Facility ID	000026	If continuation she	et Pa	ge 64 of 66

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		155066	A. BUILDING	00	COMPLETED 07/21/2011	
155000			B. WING			
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE  N MADISON AVE		
EDGEW/	ATER WOODS			RSON, IN46011		
			ID	1	(X5)	
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE DATE	
	Procedure" indicated: "2. Wash hands					
	and don gloves" The "Dressing Change					
	Policy and Procedure" indicated: "10.					
	Cleanse wound a	ccording to physician				
	order"					
	A policy dated 1/2010 and titled "Hand					
	Washing Policy and Procedure" and a					
	2/2010 policy titled "Gloves" was					
	provided by the Administrator on 7/20/11					
	at 8:25 a.m., and deemed as current. The					
	"Hand Washing Policy and Procedure"					
		Purpose 1. To prevent the				
	l <sup>-</sup>	ous disease3. When				
	washing hands with soap and water, wet					
		water, apply soap and rub				
	I -	igorously for at least 20				
		ng all surfaces of the				
	1	s. Rinse hands with				
	water and dry the					
	disposable towel. Use towel to turn off the faucetDecontaminate hands before					
		direct contact with				
	patients including					
	l ^	ands before donning				
		ades changing of gloves				
	1 -	any procedure5.				
		ands if moving form a				
		dy site to a clean body				
	site during patier					
	The "Peri-Care"	policy was provided by				
		r on 7/20/11 at 8:25 a.m.				
	This current policy indicated the					

AND PLAN OF CORRECTION IDENTIFIC		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING		COM	(X3) DATE SURVEY COMPLETED 07/21/2011		
	PROVIDER OR SUPPLIER		B. WING OTTZ 172011  STREET ADDRESS, CITY, STATE, ZIP CODE  1809 N MADISON AVE  ANDERSON, IN46011					
	SUMMARY S (EACH DEFICIEN REGULATORY OR following:  "A. Purpose 1. To cleanse the of infection, irrit the resident's pos C. Procedure7. Remove dis 8. Wipe off exce or clean area of b10. Place brief 11. remove soile 11. remove glo 20. Apply appro and/or clothing	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  e perineum for prevention ation and to contribute to ative self-image  posable brief or pad ess feces with toilet paper			N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	3.1-18(1) 3.1-19(g)(1)							